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OF

THE MEDICAL SOCIETY OF NEW JERSEY

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CONTENTS—Pages 1 to 46

EDITORIALS— Page

YEAR OF ULTIMATE DECISION 1

HOSPITALS AND FREE ENTERPRISE 2

DR. STANLEY H. NICHOLS 1890-1949 3

ORIGINAL ARTICLES—

CARDIOLOGIC ASPECTS OF RHEUMATIC DISEASES—A. D. Dennison, Jr., M.D., Maplewood, N. J. 4

NEWER THERAPEUTIC AGENTS IN PERIPHERAL VASCULAR DISEASE—Nathan Frank, M.D., Jersey City, N. J. 9

BRONCHIAL ASTHMA: SOME PRACTICAL CONSIDERATIONS—Charles Hyman, M.D., Atlantic City, N. J. 14

MANAGEMENT OF ACNE VULGARIS—S. J. Fanburg, M.D., Newark, N. J. 19

THE CHOICE OF A SUTURE MATERIAL—Stuart Z. Hawkes, M.D., Newark, N. J. 22

KOPETZKY'S CONCEPT OF DEAFNESS, TINNITUS AND VERTIGO — Henry Z. Goldstein, M.D., Newark, N. J. 27

ORIGINAL ARTICLES— Page

HYDRYLLIN FOR THE COMMON COLD—M. M. Kessler, M.D., North Arlington, N. J. 29

HYDATIDIFORM MOLE—Paul Gr[illegible]ord, M.D., Passaic, N. J. 30

STATE ACTIVITIES—

New New Jersey Fellows of International College of Surgeons 8

Psychiatric Fellowships 28

Board of Trustees Meeting 32

Specialty Societies in New Jersey 33

OBITUARIES 34

VIEWS AND REVIEWS 35

PUBLIC HEALTH NEWS 37

COUNTY SOCIETY REPORTS 38

WOMAN'S AUXILIARY 41

BOOK REVIEWS 43

TUBERCULOSIS ABSTRACTS 45

Roster of Officers, Advertising Page 3 A

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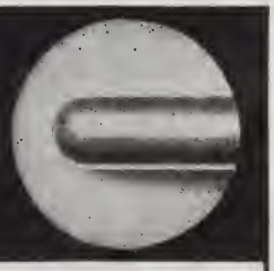

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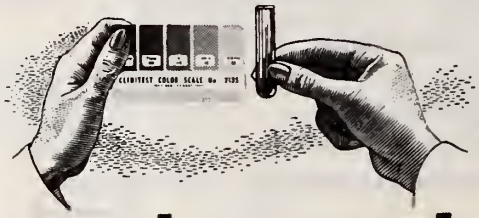

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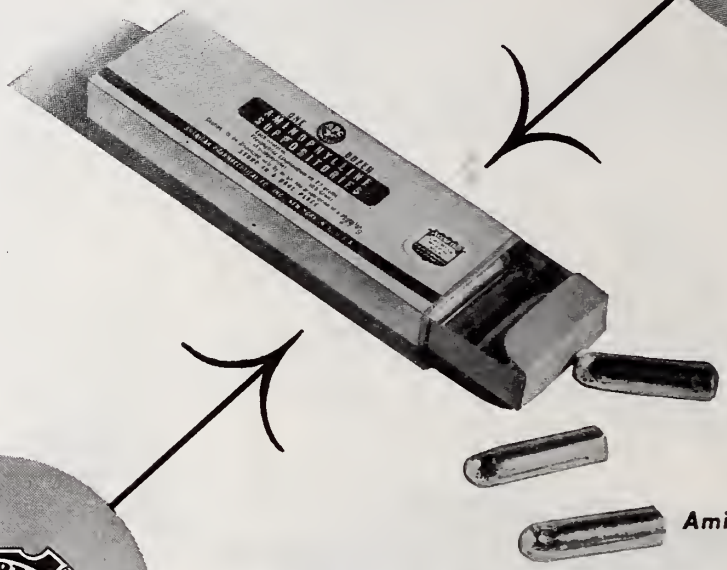

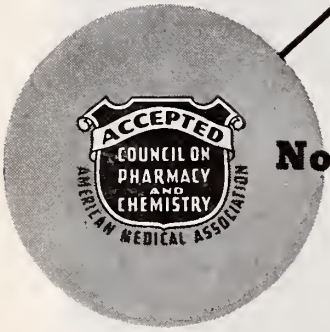

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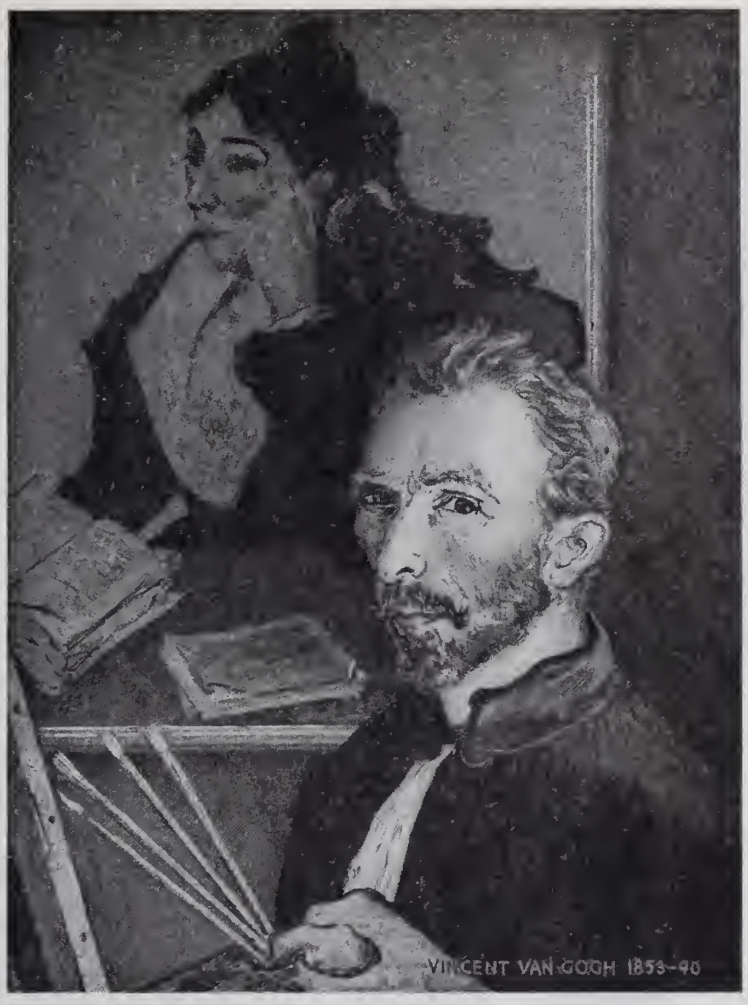

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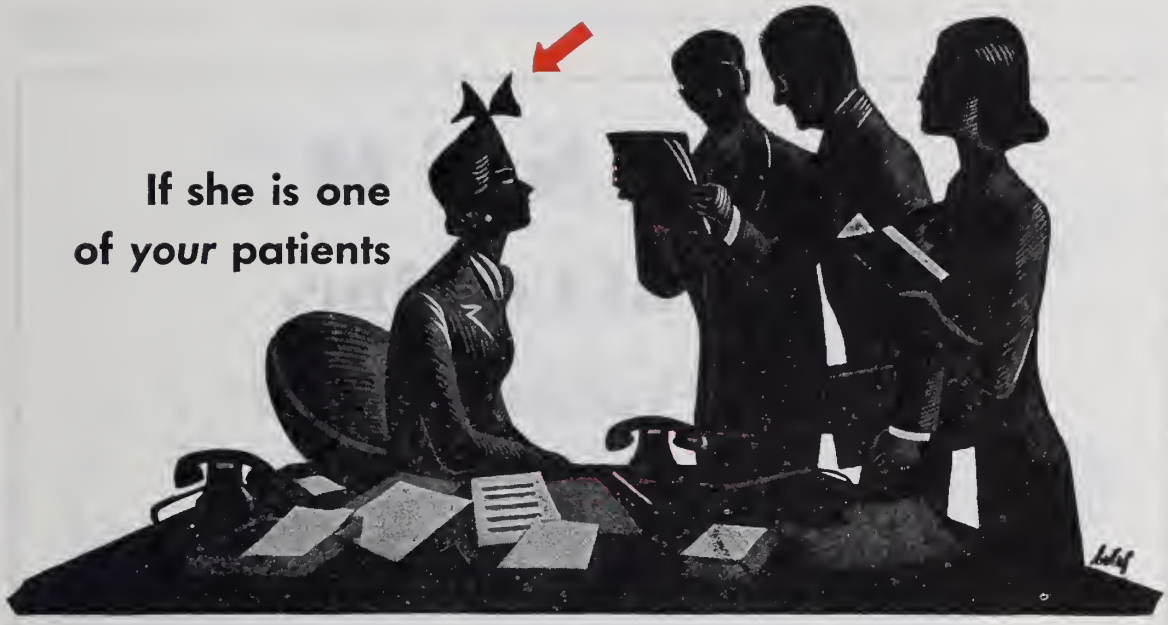

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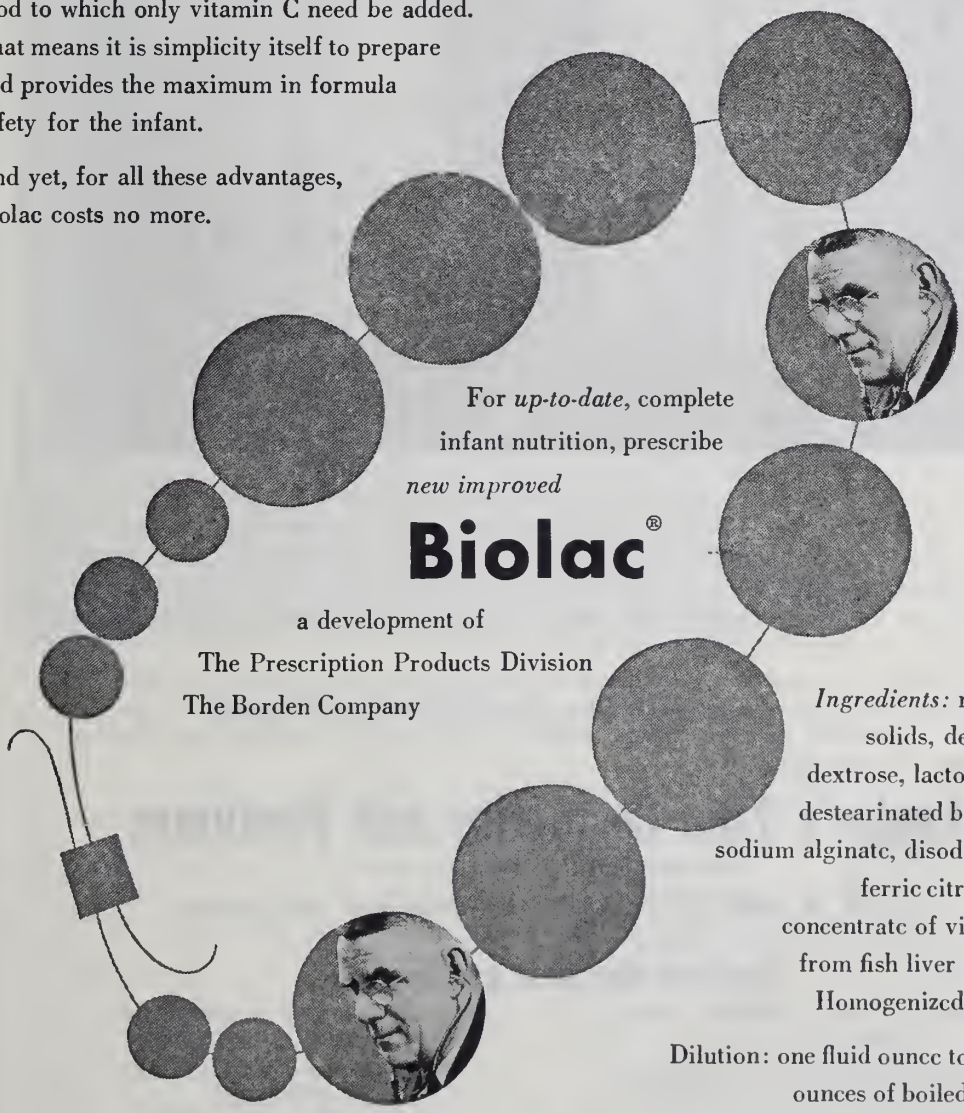

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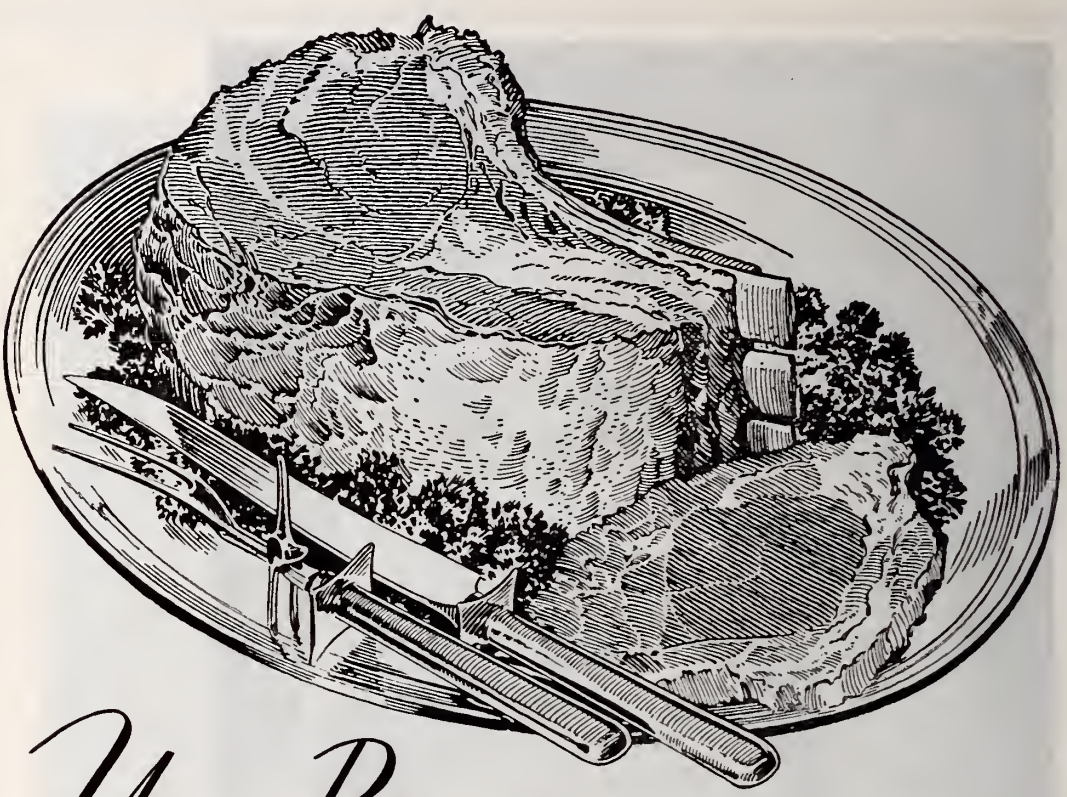

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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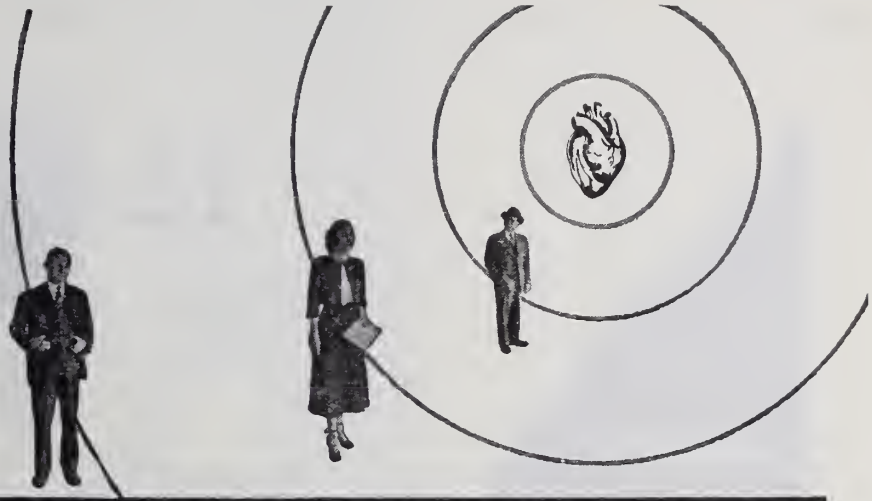

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THE JOURNAL
OF
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1950 — YEAR OF ULTIMATE DECISION

As these words are being written, votes are finally being tabulated for the 1949 by-elections. Adherents of the so-called "Fair Deal" may reasonably chortle over the returns. Except in our own gubernatorial election in New Jersey where special circumstances split the vote in certain normally Democratic strongholds, the tendency countrywide is unmistakably encouraging to proponents of the welfare state.

If there seems to be any common agreement between Fair Dealers and conservatives it is in the prediction that the major issue of the 1950 Congressional elections will be whether the people want to finish the "unfinished business" of the Fair Deal—most notably repeal of the Taft-Hartley Act and enactment of the Truman proposal for national compulsory insurance.

The task of the doctor and of every friend of freedom is unmistakably clear. The time of decision is imminent, and the challenge is undeniable.

There are just two weapons in our armamentarium — two parallel avenues down which we must attack. First, and most important, is the promotion and extension of voluntary health insurance. This is our tried and tested method of solving the problem of meeting the cost of medical care. This is our affirmative attack. We have in New Jersey a voluntary medical surgical plan nationally recognized to be one of the soundest, most advanced programs of its kind in the United States. But, as of today only one out of every twelve people in New Jersey actually has this protection.

The officers of The Medical Society of New Jersey recognize that tremendous

improvement is overdue and must be realized in the promotion and publicizing of this plan. For many months, we have been asking for a direct enrollment policy which could be available to hundreds of thousands of our friends and patients who cannot obtain this insurance program under the group requirements now in effect. We have been assured that an individual enrollment plan will be available to us by January. It will then be possible for us to say to every citizen in New Jersey, "Here at last is your plan for voluntary health insurance offering you the best of modern medical care with complete freedom of choice and at an absolute cost figure". Members of The Medical Society of New Jersey may rest assured that their elected officers will leave no stone unturned to liberate the full potential contribution of the doctor and his medical society to the most rapid possible extension of voluntary health insurance to the people of New Jersey. We can brook no obstacle. We can consent to no impediment to our efforts.

The second job facing each and every one of us is the business of alerting our fellow citizens to the imminent danger and the tragic consequences that would befall our democratic society in America if compulsory health insurance were enacted.

There can be no question but that an immense job has been done and impressive results achieved during the past twelve months. The American Medical Association and your own state society have produced the literature and have mobilized many important national and state organizations in support of our position.

Even so, we have barely scratched the surface, considering the job of public education that remains to be done. This task is essentially one of building public good will and of changing people's minds. We have set up in New Jersey a mechanism known as the "One-Ten-Twenty Plan" designed to enable every individual doctor and his wife to do their part in alerting, informing, enlisting, and stimulating their friends and neighbors to join us in this fight. The responsibility of the individual doctor under this program is limited and clearly defined. He may have all the ammunition and assistance he needs but the job ultimately must be done by him. No doctor who fails to do his full share of his job under the "One-Ten-Twenty Plan" will ever have a right again to complain about or to question what the officers of the Medical Society are doing for him.

The question whether medicine continues to be practiced in America as a free and independent art and profession —and beyond that, the question whether democracy itself will survive in America —will almost certainly come to a showdown in 1950. When the time of decision comes, doctor, will you be able to say that you have really done your part?

James F. Norton, M.D.,
President.

HOSPITALS AND FREE ENTERPRISE

Every once in a while, some medical writer makes the announcement that the organized profession has two battles to fight, not one. Federally controlled medicine is one foe; and hospital practice of medicine is a second. Without deciding at this time, the seriousness of hospital practice of medicine, one thing should be clear —the hospitals have a stake in the preservation of our American pattern of medical care. A system of federally controlled hospitals, absorbing all, or nearly all, existing institutions (as presently in Britain) would scarcely be palatable to the

American hospital interests. The very diversity of our hospitals is an asset; some are small and some gigantic, some operated by churches, some by non-profit corporations, some by cities, some by factories, some by communities, some by partnerships—this rich variety gives enormous flexibility to the hospital enterprise of America, allows any religious, racial, community or self-selected group to operate its own institutions, sets up small experimental units where both medical and administrative technics can be tried, tested, accepted or rejected. To the efficient master mind, this may seem like hopeless chaos. But its diversity is of the very breath of free enterprise, and it is inconceivable that the hospital interests of the country should not agree with organized medicine, that the system must be preserved.

All of this is but a round about way of raising a question. Have the hospitals of the country teamed up with the medical societies? If not, is it the fault of the hospitals? Or is it because, at a moment when we need all our friends, we have started to raise questions about the good faith of one of our closest allies—the hospital? This is not a call for compromise on any of our principles about corporate practice of medicine. It is, however, a suggestion that perhaps an armistice within the medical family might best serve our common needs today.

DR. STANLEY H. NICHOLS 1890-1949

"It is requested that the money customarily used for flowers be sent instead as a donation to the pastor of St. Luke's Church to be used towards meeting the needs of the hungry children of the world." This appeared in the death notices for Dr. Stanley Nichols last November. The instruction was written by Dr. Nichols himself in calm contemplation of his own death. It tells us where his interests and devotion lay far more eloquently than any obituary or editorial comment that we can write.

Stanley Nichols was a power-house of activity in behalf of human welfare. He combined to a curious and unusual degree, an honest and selfless devotion to human welfare—especially to child welfare—, a liberal and realistic appreciation of the role of government in such activities, and a firm devotion to the American way of individualism in medical care. He was an effective and persuasive organizer. Our own child health committee and the New Jersey Health Congress are both monuments to his organizing skill. And he was a skillful and talented clinician—a combination not too commonly found.

His own county medical society published an In Memoriam which merits abstracting here:

"Dr. Stanley Nichols is now with his Heavenly Father. We all know of the magnificent accomplishments of his lifetime of service, and of our regret that those accomplishments should have been cut short so soon. There was never any doubt in Dr. Nichols' mind as to his future. He knew his illness, he studied its prognosis. He fought it valiantly, and never once in the eleven months since he knew about it, did he complain. He was cheerful and his end came quietly and peacefully. He slept away. It is a source of satisfaction that his worth was so widely recognized and amply acknowledged. May he rest in peace."

ORIGINAL ARTICLES

CARDIOLOGIC ASPECTS OF CERTAIN RHEUMATIC DISEASES *

A. D. Dennison, Jr., M.D., Maplewood, N. J.

There are very few nooks and crannies in medicine that cardiology doesn't touch. Although there are approximately 21 basic causes of the various forms of heart disease, yet—remote as a disease process may be—so often its tentacles affect the heart. For example, consider a rare neurologic disease, such as Friedreich's hereditary cerebellar ataxia, with its devastating effects on the cerebellum; even in this bizarre and remote condition of the central nervous system, we find cardiac enlargement, myocardial fibrosis, and elecrocardiographic changes.

In the field of rheumatic diseases there are many reciprocal problems involving the heart. Why this should be so is something of an enigma. The joints are at some distance from the heart and their histologic pattern is vastly different. Yet the doctor laboring in the field of rheumatology must have a sound understanding of heart disease and its many ramifications. The myopic specialist who can only see the features in his own field, who sees only the joints and not the heart, (or the cardiologist who is fixed on the electrocardiogram and the sounds of the heart, neglecting the broad view of general medicine) is not a sound clinician.

As impressive as the communistic tendency of the heart in sharing disease processes in other fields, is the cosmopolitan aspect of rheumatic diseases. This point is poorly understood by the practitioner not interested in the field of rheumatism. However, a review of the inclusive classification prepared by the New York Rheumatism Association [1] and the *Primer on Arthritis* [2] approved by the American Rheumatism Association will at once reveal the almost infinite spider-webbing of this subject. No disease has been selected for discussion in this paper that does not appear in one of these two classifications.

1. Sickle cell anemia. As attending physician to the Victoria Foundation Children's Heart Hospital and Diagnostic Cardiac Clinic, I routinely checked blood smears for "sickling" on all Negro children examined in the clinic for heart disease or treated in the hospital for rheumatic fever. In the diagnosis of rheumatic fever, many conditions come up for differentiation; most prominent in the Negro is sickle cell anemia. Here is a disease that may exhibit joint pains in over 50 per cent of cases, cardiac enlargement in 48 per cent, a soft apical systolic murmur in 75 per cent, and occasionally (as reported by Klinefelter [3]) an apical presystolic or diastolic murmur. The disease may be easily confused with various types of arthritic syndromes and the cardiac aspects missed entirely. One helpful point in differential diagnosis is the little known fact that the arthralgia of sickle cell anemia does not respond to salicylates and the pain may often be located in the long bones. All young colored patients, especially females over the age of puberty should be suspected of this disease and a blood check done.

2. Gout. The age old question as to whether there is a "gouty heart" is much like the question long settled as to whether there was a "myoma heart". Present concepts are clear: there is no such thing as a "gouty heart". However, there is more than a strong suspicion of a greater frequency of vascular disease and excessive atherosclerosis in the gouty

* Read at the 183d Annual Meeting of The Medical Society of New Jersey, April 25, 1949.

1. Committee on Chronic Illness of the New York City Welfare Council, 1941, *Classification and Criteria of Arthritis.*
2. American Rheumatism Association, *Primer on Arthritis.* Journal of the American Medical Association, 139:1068 (April 16, 1949).
3. Klinefelter, H. F.: American Journal of Medicine, 203:34 (January 1942).

than in the nongouty individual. There is a high incidence of hypertension in persons afflicted with this inborn metabolic disorder and the terminal event in a gouty patient may be renal insufficiency, a coronary vascular emergency, or a cerebral accident. Thus the doctor must always scrutinize his gouty male patients for cardiovascular disease. He must know the status of their renal function and the degree of atherosclerosis in the coronary vessels. He must protect his patient as much as possible in the prevention of vascular accidents. One example of this is a fifty-year old male, currently being followed, who has typical gout with violent flareups plus evidence of peripheral arteriosclerosis with intermittent claudication and markedly depressed oscillometric readings.

3. Sarcoidosis. This fascinating and inscrutable disease has generalized manifestations that may involve any organ in the body. Bone lesions have been reported in 20 per cent of the cases and as the irregular areas of destruction occur most frequently towards the ends of the shafts of the phalanges it is only natural that arthralgia may occur, although technically the joints spaces are not involved. The punched out areas of destruction described radiographically, which have been considered typical of sarcoidosis, may also occur in rheumatoid arthritis and other chronic arthritides, gout, xanthomas, enchondromas, and true bone cysts. Recently, this disease with many subsyndromes and generalized involvement has been shown to affect the heart in a high proportion of cases. Indeed, the terminal pattern may result in myocardial failure. Unless the underlying sarcoidosis has been diagnosed, the cardiac picture may be puzzling because here we find a patient with failure of varying degree, an enlarged heart (probably without murmurs) ; no hypertension, and often electrocardiographic changes of one of the various forms of arrythmia or conduction defects, all non-specific findings. Pathologic examination reveals actual sarcoids infiltrating the myocardium and thus sudden death is not unlikely and has been reported. The picture is a serious one but as the disease has the faculty of spontaneous regression, this bears mentioning. Two points of interest in connection with this protean disease are: (1) workers with beryllium a much discussed toxin at this time, may develop a pulmonary granulomatosis that both radiologically and microscopically resembles sarcoidosis, (2) in 1941, Kveim reported a successful skin test for the detection of this disease. This test is very similar in principle to the Frei test for lymphogranuloma inguinale.

4. Serum carditis. The knowledge that the patient with painful aching joints of serum sickness (following perhaps tetanus antitoxin or horse serum for some prophylactic or therapeutic reason) may have simultaneous involvement of the myocardium or even a coronary arteritis is of some importance to the research mind. In conjunction with Rich's work on anaphylaxis and the production of periarteritis nodosa, the suspicion that rheumatic fever and the other collagen diseases may be allergic in nature, this additional information that horse serum may promote the histologic picture of inflammation in the heart muscle and about the coronary arteries, opens up a new chain of thought. But more important from the practical, clinical point of view is the need to give these people rest. That is, bedrest rather than an easy approach to the problem, letting them rest about the house or do minor tasks. This policy is becoming more important in the light of recent work showing how many infectious diseases have an associated myocarditis. These include mumps, mononucleosis, simple sore throat, tonsillitis, and other diseases that we have, in the past, been prone to take lightly.

5. Reiter's disease or syndrome. One becomes more impressed with the diffuseness of inflammatory processes when a recent report of suggested cardiac involvement in Reiter's syndrome appeared in the medical literature. This somewhat new (and now fashionable) syndrome of purulent urethritis, conjunctivitis, and arthritis, not gonorrheal in origin has heretofore not demonstrated any cardiac pathology. However, this may be the result of lack of attention to electrocardiographic and cardiac studies and to its newness in the field of medi-

cal problems. Feiring[4] reported two cases with heart block. Whether other cases properly analyzed would demonstrate cardiac findings remains to be seen. This report draws our attention again to the heart. An analysis of the serial electrocardiographic tracings reveals a first degree heart block which regressed with clinical improvement of the patient.

6. *The collagen diseases.* Perhaps never in the history of medicine, has our literature been flooded with more articles and information on any group of disorders, than on the "collagen diseases". In using this term I refer to the four much discussed ones and not the several which still remain on the dim frontier of pathologic questioning. They are periarteritis nodosa, lupus erythematosus disseminata, dermatomyositis, and scleroderma. Each arises in the differential diagnosis of the other, both clinically and pathologically. Each may give symptoms referable to the joints and also involvement of the heart. Periarteritis nodosa is significant in that involvement of the heart is second only to that of the kidneys and occurs in about 60 per cent of cases. Pains in the joints may be severe enough to simulate acute rheumatic fever, especially when several joints are involved. In addition to this, the muscle pains are also confusing. Salicylates do not influence the symptoms or the course of the disease and hypertension is not uncommon. Coronary arteritis is very frequent; yet myocardial infarction is unusual. Symptoms of coronary insufficiency are common. The hypertension (which results from renal involvement) is apparent in about half of the cases and congestive heart failure is often the terminal picture. Indeed it is the most common cause of death in periarteritis nodosa. Electrocardiographic changes are often characterized by low voltage and inverted T waves.

As late as 1945, as reported in the third edition of White's *Heart Disease,*[5] dermatomyositis was not supposed to have any cardiac manifestations. But this rare disease characterized by edema of the skin, a varying dermatitis, and a non-suppurative myositis is now known to share its muscle pathology with the special type of muscle found in the heart. Indeed cardiac abnormalities are often seen, especially in the severe cases, with myocarditis and cardiac enlargement being the cause of death. These patients frequently have considerable dyspnea due to involvement of the intercostal and diaphragmatic muscles limiting respiratory movements. The prognosis is very poor.

Very much like dermatomyositis is *scleroderma.* The advanced stages of dermatomyositis may be confused clinically and pathologically with scleroderma. Allergy has been considered a prominent etiologic factor. Allergists and clinicians are puzzled by the similarity of the pathologic picture to rheumatoid arthritis, rheumatic fever, and some other anaphylactic states. It is not uncommon in this condition to have symptoms referable to the joints suggesting a diagnosis of rheumatoid arthritis before the scleroderma process becomes active. An x-ray of the involved parts may show decalcification of bone or even loss of bony substance in the terminal phalanges. But the full-blown picture of tense, hardened, and brawny skin with a peculiar leathery induration, either diffuse or circumscribed, once seen is never forgotten. Again in this condition the involvement so vivid in the skin may extend to the esophagus with fibrosis; to the lungs with a diffuse fibrotic process and varying degrees of shortness of breath; and to the heart. Weiss[6] has reported a group of cases with evidence of cardiac enlargement in all. Radiographically, a peculiar triangular enlargement of the heart (much like that seen in myxedema heart disease or pericardial effusion) has been reported. These are indeed sick people. As one would expect, the electrocardiogram again shows low voltage—a diffuse muscle process inhibiting electrical conduction.

No discussion of the collagen diseases would be complete without mention of acute disseminated lupus erythematosus and its associated Libman-Sacks syndrome. It is not unusual to give a patient a label of rheumatoid

4. Feiring, William: Annals of Internal Medicine, 25:498 (September 1946).

5. White, Paul D.: *Heart Disease.* 3d Edition. Macmillan, New York, 1945 (page 559).

6. Weiss, Soma, *et al.*: Archives of Internal Medicine, 71:749 (June 1945).

arthritis, only later to be forced to change the diagnosis to this syndrome. For arthritis, pleurisy, and other vague complaints may long precede the appearance of the typical classical condition so frequently being reported in the medical literature today. No tissue in the heart has not been involved in lupus.[7] It is not easy to evaluate the severity of the cardiac lesions in Libman-Sacks syndrome, or in the disseminated phase of lupus. The influence of the anemia, the involvement of the lungs, the poor nutritional state, the likely existence of pericarditis, the varying severity of involvement of both myocardium and endocardium (so that even at autopsy the pathologist finds difficulty in searching out the lesions) makes the cardiologist's or rheumatologist's problem a keen one. Electrocardiographic data are non-specific with lowered amplitude of the waves being prominent. No pattern is completely unexpected. Treatment appears of little avail and the recent flurry of interest in paraminobenzoic acid in scleroderma and lupus needs close scrutiny as to the value of the drug.

Twenty-five years ago, the medical student was graduated always knowing one disease with great thoroughness—that is typhoid fever. Today, no graduate gets through medical school without being saturated with all aspects of rheumatic fever, and rheumatic heart disease, active and inactive. The recent graduate is a keen case finder and most physicians are now imbued with the need for bed-rest in acute rheumatic fever. The epigram that rheumatic fever is a disease which "licks the joints and bites the heart" summarizes completely the whole problem. This is indeed one condition in which attention to treatment referable to the heart is paramount.

CONCLUSION

A group of clinical conditions with cardiac and rheumatic manifestations have been selected for brief discussion. The selections of these conditions has been very arbitrary. The number of mutually affected conditions is legion ranging from joint pains in a hypertensive given potassium thiocyanate treatment to as remote a condition as acromegaly with its cardiac and rheumatic pathology.

The whole problem of the heart in rheumatoid arthritis remains an enigma. A plea is made for total evaluation of the patient and for a therapeutic approach which is not limited anatomically to the heart or the joints. The frequent occurrence of cardiac involvement in rheumatic diseases is pointed out in spite of their vastly different histologic picture and anatomic location. The appreciation of the ramifications of both specialties, cardiology and rheumatology into the general aspects of medicine today is again emphasized.

601 Ridgewood Avenue

DISCUSSION

HENRY L. DREZNER, Trenton: I am pleased by Dr. Dennison's repeated emphasis on the correlation of rheumatic diseases with the various cardiopathies. It would be a pity if we continued as specialists in acute rheumatism as distinct from specialists in chronic rheumatism. The fields are intimately interrelated as you have had clearly demonstrated here today. We should be more cognizant of this relationship in our work. We should never be accused of losing sight of the forest because of the trees.

There are those who believe that rheumatic fever and rheumatoid arthritis are related and point out the histologic similarity of the subcutaneous nodules occurring in both conditions. Of the twenty-three autopsy cases of rheumatoid arthritis studied by Dr. Bayles of Boston, twenty-two per cent had rheumatic cardiac lesions. In studying the causes of death in thirty cases of rheumatoid arthritis, Drs. Rosenberg, Baggenstoss, and Hench found cardiac lesions indistinguishable from those of rheumatic heart disease in sixteeen cases. These findings cannot be coincidental and, in my opinion, are further evidence of the relationship. White has said: "In rheumatoid arthritis also of unknown etiology, pericarditis, endocarditis, and myocarditis may infrequently appear as complications not to be ascribed at least in all cases, to a coincident rheumatic fever". Of course, there are many who believe that the characteristic nodules common in both conditions can be differentiated. Be that as it may, one cannot help but wonder as to the similarity of these diseases.

The paper covered a number of disease entities

7. Humphreys, Eleanor: Annals of Internal Medicine, 28:12 (January 1948).

with their cardiac implications; their kinship has been clearly and ably presented. I feel, however, that the discussion would not be complete without a word about the neurovascular syndromes of the shoulder girdle and peripheral vascular disturbances. One cannot help but comment on the circulatory changes that occur with the cervical rib and scalenus anticus syndromes and yet, pain in the involved extremity is one of the prominent features of the disease. The pain in the hands and fingers in the costoclavicular and hyperabduction syndromes is also characteristic and yet, the pathologic physiology is directly attributable in a large measure to an interference in the circulation of the extremity.

In the obstructive vascular diseases such as arteriosclerosis obliterans and thromboangiitis obliterans, we find pain in the extremities as one of the cardinal features. Here, too, the underlying mechanism is a circulatory defect. Some mention should be made of essential polyarteritis. This has often been linked with the "collagen diseases". It is not unusual to encounter an anginal syndrome with severe joint pain in the same subject. Lamb reported joint pain in thirty-nine per cent of the series under his study. Wright in his book on peripheral vascular diseases, states "This symptom (referring to the pain) together with myositis, neuritis, and sore throat, suggests a relationship to a rheumatic or arthritic syndrome".

I was recently attracted by an article in the July 1948 American Journal of Medical Sciences on amyloidosis in rheumatoid arthritis. The investigators concluded that amyloid disease in rheumatoid arthritis is far greater than is generally believed and, even though the amyloid process is not directly responsible for the death of the patient, it certainly contributes to the myocardial degeneration and subsequent failure.

How often the question of differential diagnosis between acute subdeltoid bursitis and coronary insufficiency arises is familiar to all of us.

Whereas all of these problems related thus far demonstrate the cardiac and circulatory changes on a causal or complicating basis, it must be stated here that the converse is also true. Witness the reflex dystrophies wherein the symptoms and signs in the extremities result from a cardiac episode. I have in mind the shoulder-hand syndrome, post infarctional. For many years, clinicians have been aware of the occurrence of persistent painful shoulder disability complicating coronary occlusion. Howard, in 1930, emphasized the importance of recognizing this association for two reasons: (1) Pain of the shoulder might be mistaken for severe cardiac pain, or (2) the shoulder lesion might receive attention while the changes in the heart are overlooked. Ernstene and Kinell noted the occurrence of persistent pain in one or both shoulders as a relatively common sequel to myocardial infarction. Many others have found the same sequence of events and have regarded the combination of the shoulder-hand symptom following an infarction as a definite syndrome. All this must make us ever-conscious of the multitudinous manifestations and ramifications of rheumatism and thereby keep us on guard for their appearance and proper evaluation.

Author's Note: Essential polyarteritis was discussed at length in the paper under the more commonly used and recognized term—periarteritis nodosa.

NEW NEW JERSEY MEMBERS OF INTERNATIONAL COLLEGE OF SURGEONS

The following surgeons from New Jersey were elected to Fellowship or Associate Fellowship or promoted within the International College of Surgeons at the annual convocation of that organization on November 11, 1949:

CERTIFIED FELLOWS

Frank G. Barnard, Montclair
William C. Ivins, Trenton
Charles Littwin, Teaneck
Lewis E. Savel, Newark
Baxter H. Timberlake, Atlantic City
Matthew F. Urbansky, Perth Amboy
Rostin White, Somers Point
Philip Willner, Newark

ADVANCED TO RANK OF CERTIFIED FELLOWS

Guy B. Griffin, Orange
M. Browne Holoman, Margate City
Kenneth H. Judy, Jersey City
James V. Lyons, Orange
Bernard A. O'Connor, Harrison
Ernest F. Purcell, Trenton

ASSOCIATES

Arthur A. Allen, Paterson
Joseph P. Catania, Garfield
Joseph K. Catlaw, Jersey City
Allan B. Crunden, Jr., Montclair
Charles H. Finke, Jersey City
Walter T. Gutowski, Irvington
John G. Imhoff, Jersey City
Irving Marshall, Jersey City
Josiah E. Obert, New Egypt
Mario V. Pizzi, Orange
Fred Sachs, Jersey City
David P. Simpson, Bayonne
Ronald J. Walsh, Elizabeth

NEWER THERAPEUTIC AGENTS IN PERIPHERAL VASCULAR DISEASE *

NATHAN FRANK, M.D., Jersey City, N. J.

Several new agents in the treatment of peripheral vascular diseases have appeared on the therapeutic horizon during the past few years. It is my purpose to describe their actions and to evaluate their use. These drugs include: diethyl ether, histidine and ascorbic acid, dibenamine, vitamin E, tetraethyl ammonium and priscol. We, at the Jersey City Medical Center, have had personal experience with the latter three drugs.

Diethyl ether—In 1946, Katz[1] reported treatment of diabetic arteriosclerosis obliterans with intravenous diethyl ether. This was administered in a 2½ per cent solution of 5 per cent glucose and distilled water. Both solutions were refrigerated to protect against explosion. The infusion was given slowly, taking at least 1½ hours and was administered daily for twelve days. He reported marked relief of ischemia and pain. Eighty per cent of the patients treated for impending ischemic gangrene and pain were saved from amputation. Diethyl ether therapy also gave hopeful results in patients with non-diabetic arteriosclerosis obliterans, Reynaud's syndrome, thromboangiitis obliterans and other angiospastic conditions. He was unable to explain the mechanism of action of this drug.

Lichtenstein and Sewell[2] reported the death of a seventy-five year old patient during the course of an infusion with diethyl ether. Autopsy revealed definite pulmonary and cerebral embolism. They hypothesized that the fat emboli resulted from the liberation of free fat by the ether from the lipid envelope of the erythrocytes or the emulsified fat of the plasma. Wirtschafter and Widmann[3] noted the development of jaundice and hematuria following use of this drug.

If diethyl ether is to be employed in the treatment of peripheral vascular diseases, it seems a reasonable precaution to investigate the status of hepatic and renal function of the patient.

Histidine and Ascorbic Acid—Wirtschafter and Widmann[3] believed that the vasodilating effect of diethyl ether was based on the release of histamine. They searched for some other, relatively innocuous way to obtain a similar release of histamine, and recalled the work of Holtz,[4] who reported the conversion of histidine to histamine *in vitro* by the action of ascorbic acid. Their method is as follows: patients were first given 500 milligrams of sodium ascorbate intravenously. This was followed by the intramuscular injection of 5 cubic centimeters of 4 per cent aqueous solution of histidine monohydrochloride simultaneously with the subcutaneous injection of 100 milligrams of sodium ascorbate. The subsequent regimen consisted of giving the two organic compounds in the manner described every 4, 6, 8 or 12 hours depending on the severity of the clinical findings. In addition, patients received 600 milligrams of ascorbic acid orally daily.

To demonstrate the presence of histamine, the serum and urine of the subjects were injected intradermally into normal non-allergic individuals. In all cases, typical and decidedly strong wheals and flares were produced. The wheals obtained were of greater intensity and persisted for a longer time than those produced with serum obtained from patients treated with diethyl ether.

Eleven patients with peripheral vascular disease were treated with ascorbic acid and histidine as described. All responded favorably. None required amputation. Evaluation of improvement were based purely on clinical observation. No laboratory studies were done to determine changes in the circulation. Friedell, Drucker and Pickett[5] treated 25 patients with arteriosclerosis obliterans by this method. They all had failed to respond to conservative therapy, i. e. rest, sympathetic block, vasodilants. Some were given the medication orally and some parenterally. Skin temperature studies and oscillometric readings were not informa-

* Read at the 183d Annual Meeting of The Medical Society of New Jersey, April 26, 1949.

1. Katz, R. A.: New Orleans M. and S. J., 98:542 (1946). Amer. Heart J., 35:869 (1948).
2. Lichtenstein, L., and Sewell, S.: J.A.M.A., 136:827 (1948).
3. Wirtschafter, Z. T., and Widmann, R.: J. A. M. A., 136:604 (1947).
4. Holtz, P.: Nauturwissenschaften, 25:14 (1937).
5. Friedell, M. F., Drucker, E. F., and Pickett, W. J.: J. A. M. A., 138:1036 (1948).

tive as to improvement in circulation. Changes in the circulation were also studied by using isotopes such as radioactive phosphorus. Their best criteria for improvement were clinical. No untoward effects occurred in any of their patients. They concluded that: (1) parenteral histidine and ascorbic acid relieves the pain of arteriosclerosis obliterans in the majority of cases; (2) it improves the objective signs; (3) hastens demarcation, and (4) improves the circulation as demonstrated by isotope studies.

A new development in histamine therapy has recently been reported by Mufson.[6] This consists of weekly and biweekly intra-arterial infusion of 1.35 to 2.75 milligrams of histamine. Mufson has given over 500 such injections without mishap. His circulatory studies consisted of skin temperature, oscillometric readings and diffusion of radioactive sodium. Histamine by arterial infusion acted as a powerful dilator of all the components of the peripheral vascular system. The increase of the temperature of the skin and radiosodium diffusion indicated that the arteries, large and small, are widened. The erythema of the skin which follows means that the precapillary sphincters are relaxed and the minute vessels are opened. The superficial veins become visibly dilated. These responses are probably as short lived as six hours; still, as the results show, cumulative and mounting improvement follows weekly infusion. The explanation for its beneficial effect is the opening of the spastic collaterals. He reported marked improvement in walking tolerance in 85 per cent of patients. Sleep pain was relieved in all cases. Relief was noted after three to six treatments.

Vitamin E—Shute[7] and his co-workers reported remarkable results in indolent varicose ulcers, thrombophlebitis, early gangrene of the extremities and thromboangiitis obliterans after the administration of alpha-tocopherol. They have reported equally astonishing results in coronary, hypertensive and rheumatic heart disease and in cerebral thrombosis. Their findings are based on clinical observations. Vitamin E has no known pharmacologic action supporting the belief that it has a vasodilating action. In our hands and in those of other observers, it has been found to be entirely inert.

Dibenamine[8] structurally resembles the nitrogen mustard gases. The intravenous route is the only effective mode of administration. In physiologic doses, dibenamine is an effective adrenergic blocking agent. The blocking action upon the responses to sympathetic nerve stimulation develops more slowly and less completely than its blocking action upon the responses to adrenalin. The effects of a single injection last 36 to 96 hours. Resting blood pressure, heart rate and the electrocardiogram in normotensive individuals are not significantly altered. Orthostatic hypotension occurs in both normotensive and hypertensive patients and is elicitable for 12 to 24 hours after administration of the drug. Postural tachycardia persists even longer. It increases peripheral blood flow and elevates skin temperatures, particularly in patients with neurogenic vascular spasm of the extremities.

On the basis of its pharmacologic actions, dibenamine and its congeners should be of value in conditions in which partial or complete blockade of excitatory adrenergic functions is indicated for diagnostic purposes or symptomatic or specific therapy. These conditions include peripheral vascular diseases such as thrombophlebitis, acute arterial occlusion, frost bite, causalgia, Reynaud's disease, organic vascular insufficiency with components of functional spasm. However, Hecht[9] and his group found that this drug caused toxic reactions in almost all their patients. The most remarkable was a psychic disturbance consisting of repetitive perceptions of actual events and hallucinatory episodes associated with a disturbance of time sensation. This peculiar mental state occurred in 15 per cent of patients. Other untoward reactions included nausea, local thrombophlebitis, convulsions and severe nasal congestion. General opinion is that dibenamine in safe

6. Mufson, I.: Ann. Int. Med., 29:904 (1948).
7. Shute, E. V., Vogelsang, A. B., Skelton, F. R., Shute, W. E.: S. G. O., 86:1 (1948). Vogelsang, A. B., Shute, E. V., Shute, W. E.: Med. Rec., 160:22 (1947), 160:91 (1947), 160:163 (1947), 160:230 (1947).
8. Nickeson, M., and Goodman, L. S.: Fed. Proc., 5:194 (1946). Nickeson, M., and Goodman, L. S.: Fed. Proc., 7:397 (1948).
9. Hecht, H. H., and Anderson, R. B.: Amer. J. Med., 3:3 (1947). Hecht, H. H., Focht, S. F., Abildskon, J. A., Burns, T. W., and Christensen, R. O.: Amer. J. Med., 3:124 (1947).

doses is a valuable pharmacologic tool but it appears to have limited therapeutic possibilities.

Tetraethyl Ammonium has a vasodepressor action which was abserved many years ago by Marshall, Pritchard and Trendenlenburg. Acheson and Moe [10] and Acheson and Pereira [11] in 1946 brought it again to the attention of the medical profession.

They conclusively demonstrated that the drug exerted its effects by blocking the ganglia in the efferent pathways of the sympathetic and parasympathetic nerves. Acheson and Moe [10] showed that intra-arterial injection of tetraethyl ammonium caused no increase in blood flow of the leg of the dog but intravenous injection did. Berry [12] reported that tetraethyl ammonium caused a rise in skin temperature in man equal to or greater than that caused by sympathetic block. Slaughter [13] asserted that it increased the blood flow in the upper extremities 100 per cent and 135 per cent in the lower extremities in a group of normal persons. These observations were based on plethysmographic studies.

Lyons [14] and his co-workers treated a great variety of conditions with favorable effect. Their method consisted of either intravenous or intramuscular administration. By vein, the dose ranged from 100 to 500 milligrams. Most patients received 500. Intramuscular therapy was given only to hospitalized persons. The dose was calculated on a basis of less than 20 milligrams per kilogram body weight. The average dose was 1000 to 1500 milligrams. They felt that the drug produced an autonomic ganglion blockade as efficient as that obtained by sympathetic block. Results in thromboangiitis obliterans, thrombophlebitis with evidence of vasospasm, causalgia, Reynaud's disease, acrocyanosis, pernio and other vasospastic states was excellent. In arteriosclerosis obliterans it helped control night pain. In a later report,[15] these same investigators felt that they were over-enthusiastic about their results. They still felt that tetraethyl ammonium was a valuable diagnostic aid but agreed that it did not replace sympathectomy for therapy. Debakey [16] and Pearl [17] independently found that local nerve and regional sympathetic block invariably produce an increase in the skin temperature from two to six times greater than the increase caused by tetraethyl ammonium. Of particular significance is the fact that local nerve and regional sympathetic block always resulted in an increase in skin areas which had failed to respond to the use of the drug. Finally the duration of the elevation following block was in every instance considerably more prolonged than the rise following the use of the drug. They concluded that the drug was of no value therapeutically and diagnostically. This coincides with my own impression. It has many undesirable reactions such as postural hypotension, weakness, poor muscle control, anuria, hyperventilation, inhibition of gastrointestinal motility and bladder tone, nausea, vomiting and occasional marked peripheral collapse. Friedlick [18] reported a case in which the patient went into a prolonged shock-like state following the intravenous administration of 230 milligrams of tetraethyl ammonium. One death has been reported to date which could be attributed to this medication.[19]

Priscol was first reported by Hartman and Isler [20] in 1939 as a possible agent in the treatment of hypertension. At approximately the same time, Meier and Muller [21] demonstrated the vasodilatory action of priscol, stating that it was more pronounced in the extremities. They were the first to demonstrate that priscol and adrenalin given together produced lowering of the blood pressure. Meyer,[22] in 1941, proved the adrenolytic properties of priscol. In 1947, Ahlquist, Huggins and Woodbury [23] reported that priscol produced peripheral vasodilatation, increased cardiac output over peri-

10. Acheson, G. H., and Moe, G. K.: J. Pharm. and Exp. Th., 87:220 (1946).
11. Acheson, G. H., and Pereira, S. A.: J. Pharm. and Exp. Th., 87:273 (1946).
12. Coller, F. A., Campbell, K. N., Berry, R. E. L., Sutler, M. R., Lyons, R. H., and Moe, G. K.: Surgery, 125:729 (1947).
13. Slaughter, O. L., Brown, H. S., and Wakim, K. G.: J. Lab. Clin. Med., 33:743 (1948).
14. Lyons, R. H., Moe, G. K., Neligh, R. B., Hoobler S. W., Campbell K. N., Berry, R. L., and Rennick, B. R.: Am. J. M. Sc., 213:315 (1947).
15. Coller, F. A., Campbell, K. N., Berry, R. E. L., Sutler, M. R., Lyons, R. H., and Moe, G. K.: Surgery, 125:729 (1947).
16. DeBakey, M. E., Burch, G., Ray, T., and Oehsner, A.: Ann. Surgery, 126:850 (1947).
17. Pearl F.: Ann. Surgery, 128:1092 (1948).
18. Friedlick, A. L., Jr., Chapman, W. P., and Stormbury, J. B.: N.E.J.M., 238:629 (1948).
19. Lasser, R. P., Rosenthal, N., and Loewe, L.: J.A.M.J., 139:15 (1949).
20. Hartman, M., and Isler, H.: Exp. Path. und Pharm., 192:141 (1939).
21. Meier, R., and Muller, R.: Schweizerische Med. Wochens, 69:1371 (1939).
22. Meyer, R. T.: Med. Acta. Supp., 18:1941 (Addition to Vol. VIII).
23. Ahlquist, R. P., Huggins, R. A., and Woodbury, R. A.: J. Pharm. and Exp. Th., 69:271 (1947).

pheral vasodilatation. Hatt,[24] using the Starling heart-lung preparation, demonstrated that damaging doses of priscol were 100 times greater than those used to reduce blood pressure. Grimson, Reardon, Marzoni and Hendrix[25] in a recent study confirm the reports of the South American and European investigators. They found that single doses of 50 to 75 milligrams, with few exceptions, produced changes in the circulation of limbs equivalent to those produced by sympathetic block or sympathectomy. Continuing treatment by this dose schedule maintains benefit but does not entirely equal the effect of sympathectomy. Results in Reynaud's disease have been so encouraging that sympathectomy is no longer utilized. Results in causalgia and other vasospastic states showed the drug is of definite value. In arteriosclerosis and thromboangiitis obliterans the results were not as striking but were definitely encouraging. They did not observe any deleterious effects of the above doses on co-existing coronary artery disease. Oscillometric readings were unchanged in marked arterial occlusive disease and improved in cases with mild or moderate involvement. Postural hypotension occurred after the administration of very large doses. They felt that the drug has a definite adrenalin blocking action in view of its action on sympathectomized limbs.

JERSEY CITY RESULTS

This report deals with results of clinical investigation of priscol in various peripheral vascular disorders at the Jersey City Medical Center over a period of twenty-two months.

Patients for study were referred to the peripheral vascular disease clinic of the Jersey City Medical Center. Each room contained six examining tables. Each patient rested for one hour before studies were started. Room temperatures fluctuated slightly. Complete physical examination was supplemented by oscillometric readings of the lower extremities at the foot, ankle, calf and thigh and temperature readings of each of the toes and of the dorsum of the foot. Laboratory studies included urinalysis, complete blood count, blood sugar, blood non-protein-nitrogen, Wassermann, electrocardiogram and soft tissue x-rays of the lower extremities. Gastro-intestinal studies were done on two cases. Patients were seen weekly for two months and then every two weeks thereafter. Patients who were incapacitated were hospitalized and treatment with priscol was regulated by one of us. To determine the distance a patient could walk after therapy, a circle thirty yards in circumference was mapped out. The patients were permitted to walk this circle until the beginning of calf pain. If the patient walked one mile without pain he was permitted to stop. Because many of the patients started therapy before a walking test could be done, it was necessary to approximate the distance the patient could walk prior to therapy according to his own history, the average block measuring eighty yards. On discharge, the patient was referred to the peripheral vascular disease clinic for follow up care. All patients were cooperative and at the present time are still being followed.

The twenty-two patients studied exhibited the following diseases: peripheral arteriosclerosis (15); arteriosclerotic heart disease (7); hypertension (8); hypertensive heart disease (3); thromboangiitis obliterans (3); diabetes (2); anginal syndrome (1); frostbite (1); rheumatic heart disease (1); syphilis (1); duodenal ulcer (3); Reynaud's disease (1); coronary artery disease (7). Eleven cases exhibited definite calcification of the peripheral vessels, four had ulceration of the fingers or toes, three had already had amputations performed. One coronary artery disease with infarction exhibited signs and symptoms interpreted as saddle thrombus. The age range was 29 to 75, average being 56. Those with thromboangiitis obliterans ranged from twenty-nine to forty-four, average being thirty-nine. Those with arteriosclerosis ranged from fifty-one to seventy-five, average being sixty-two.

Results—Results of treatment with priscol in the cases studied were uniformly good. Average daily dose orally was 200 to 250 milligrams in divided doses. Highest oral daily amount was 500 milligrams taken in divided doses. Average intravenous dose was 50 milligrams three times a day. Greatest daily intravenous dose was 240 milligrams given in doses of 30 milligrams every four hours. All patients exhibited increased collateral circulation as demonstrated by temperature studies. Intermittent claudication was abolished or greatly diminished in the majority of patients. All patients stated that their feet were warmer and that they felt much better than before

24. Hatt, F.: Helvet, Med. Acta. Supp. VII, 70:1941 (Addition to Vol. VIII).
25. Grimson, K. S., Reardon, M. J., Marzoni, F. A., and Hendrix, I. P.: Ann. of Surgery, 127:968 (1948).

treatment. In the cases of thromboangiitis obliterans and frostbite all ulcerations healed, the anginal syndrome was markedly improved and the case of saddle thrombus survived. In general, blood pressures were lowered, but lack of sufficient studies prevents further comment along this line at this time. Excellent results were obtained in the arteriosclerotic group. In the thromboangiitis obliterans group, best results were obtained with either large oral doses or relatively large intravenous doses. There were no alarming signs or symptoms. Of two known cases of duodenal ulcer, one experienced epigastric pain controlled by antacids, while the other had no complaints. A third patient who gave no history suggestive of duodenal ulcer experienced anorexia, epigastric pain and nausea, and a subsequent gastro-intestinal series revealed an active duodenal ulcer. Symptoms were controlled by reducing the dosage of priscol and giving routine ulcer therapy. Other side reactions were flushing, increased pyelomotor activity and tingling.

CONCLUSIONS

1. The physiologic, pharmacologic and clinical effects of diethyl ether, histidine and ascorbic acid, vitamin E, dibenamine, tetraethyl ammonium and priscol have been presented.

2. Vitamin E and histidine and ascorbic acid are felt to be relatively inert.

3. Diethyl ether, dibenamine and tetraethyl ammonium are efficient vasodilators but are often followed by severe reactions.

4. A report is submitted of the treatment with priscol of 22 patients at the Jersey City Medical Center.

5. Of all the drugs discussed, priscol and intra-arterial histamine appear to be of the greatest clinical promise.

6. Treatment of peripheral vascular diseases should be based on the time-honored methods such as bed rest, intermittent venous occlusion, oscillating bed, reflex vasodilation by the distal application of heat, local and sympathetic nerve blocks, sympathectomy, vascular exercises, foot hygiene, etc. Vasodilators should be used to supplement and not replace these measures.

180 Bowers Street

FIFTY YEARS AGO

From the minutes of 1899 meeting of The Medical Society of New Jersey: (report of the committee on arrangements): "The managers of this hotel, the Allenhurst Inn did not expect a rush, but they have been the victims of prosperity and now have 158 permanent guests. Three years ago the town of Allenhurst was not in existence and this place was a mere farm.

"This is my fifth year as chairman of the committee on arrangements. Up to last year, there had been considerable friction between the committee and the exhibitors. Last year the exhibitors paid nothing. This year, each exhibitor pays one dollar to defray actual exhibit expenses. This plan seems satisfactory and may be adopted for future meetings. After this opening session, meetings will be held on the beach pavilion unless the surf makes too much noise." From page 32 of the 1899 *Transactions of The Medical Society of New Jersey.*

ONE HUNDRED YEARS AGO

"The brilliant galaxy of science is rapidly dispersing the fogs of ignorance; and the idea once generally cherished that The Medical Society of New Jersey was a Hydra, branching through every section of the state for sole purpose of enriching ourselves is happily becoming obsolete. The medical horizon is calm and serene. The whole circle of heavens, but partly obscured by the reckless boldness of the empirics,* their indefatigable efforts to nullify all philanthropic exertions, vilify every legitimate discovery, gives a gloomy and portentious aspect to the future; but experience has taught, however dark, may be their aspect, they are *vox et praeterea nihil;* they may whistle awhile but are rapidly passing away." (Report of Standing Committee, page 431 of 1849 *Transactions* of The Medical Society of New Jersey).

* An empiric is a practitioner whose knowledge was derived entirely from practice, and who has had no formal study. The Latin phrase reminds us that in those days, physicians really knew the classical language. For the benefit of the younger Philistines, the italicized words mean "A voice and nothing else," that is—sound without substance.—Editor.

BRONCHIAL ASTHMA: SOME PRACTICAL CONSIDERATIONS*

CHARLES HYMAN, M.D., Atlantic City, N. J.

Modern research in allergy has contributed a great deal to our understanding of the fundamentals involved in the excitation and the production of the asthmatic state. However, even with all this information we are often hard pressed to prevent this distressing syndrome, and we are as frequently hard pressed in interrupting the asthmatic state. The advent of each new therapeutic agent has given rise to high hopes that here at last is the long sought panacea. Many of these agents have been used without consideration of the etiologic or physiologic factors involved in an asthmatic attack. Others have been directed at some part of the pathologic physiology. Each new method is heralded by glowing reports of long chains of successes. Each new treatment becomes the vogue. Enthusiasm dies down in due time as a result of a string of failures, or even worse, some serious and untoward reactions.

Large doses of viosterol, deep surgical anesthesia, x-ray therapy over the spleen or over the paravertebral area, adrenalin nebulization, adrenalin in oil, aminophyllin by various routes, sinus surgery, typhoid vaccine by vein, fever therapy, chemotherapy, antibiotics and the antihistaminic drugs, have all had their advocates. With the march of time each method has fallen into its respective place or fallen into disrepute as the case may be.

As a result, confusion now exists in the management of a serious and disabling disease. It would be well for all of us to reevaluate our means of treating the asthmatic patient. Research in allergy has provided for us a rich store of information relative to the etiologic, pathologic and physiologic aspects of the asthmatic state. Proper management presupposes a knowledge of these factors. Important also is a proper diagnosis. This may seem like an unneccessary precaution since asthma is so easily recognized and the patient generally gives you the diagnosis himself. But many conditions, some common, some rare, must be considered in the differential diagnosis. All that wheezes is not asthma.

A 61-year old male was referred for skin testing to determine the cause of his "asthma". The family doctor first saw this patient two months before in a typical asthmatic attack which responded to adrenalin. Following this he had relief from ephedrine. He had been perfectly well until six months ago when he noted gradually increasing cough. Three months ago he started to wheeze and developed some dyspnea on exertion. Then followed the acute asthmatic attack that responded to adrenalin. On this examination wheezing was confined to the lower two-thirds of the right chest. Many other physical signs were present, but there was already enough for a diagnosis of intermittent bronchial occlusion. Bronchoscopy confirmed the diagnosis of bronchogenic carcinoma of the right main stem bronchus.

A 52-year-old male was sent to the dispensary by police ambulance. The referring physician stated that this man's "asthmatic attack" was not relieved by adrenalin. The patient was orthopneic, cyanotic and in marked respiratory failure. All the accessory muscles of respiration were in play, but no wheezing could be heard in the lung fields. Respiratory sounds were conspicuously absent. The alert house officer suspected an obstructive dyspnea. Direct laryngoscopy was performed and an edematous larynx was demonstrated. An antero-posterior film of the chest revealed a large superior mediastinal mass. Breathing was facilitated by direct intubation with oxygen. Subsequent studies when his condition improved disclosed the mass to be a large aneurysm of the aorta.

Many similar problems in differential diagnosis could be cited—such as paroxysmal nocturnal dyspnea, bronchial tuberculosis, foreign bodies, uremic states, left ventricular failure and a variety of other conditions which may mimic asthma.

Many of the pitfalls in the diagnosis could be avoided by a careful and detailed history, if the examiner keeps in mind the diseases that mimic asthma and the two types of asthma with which one has to deal. While there is no unanimity of opinion, for practical purposes one may consider a non-infective and an infective type of asthma. The non-infective type

* Presented by invitation before The Medical Society of New Jersey, Annual Meeting, April 26, 1949. Dr. Hyman is Medical Chief of the Atlantic City Hospital.

is produced by means of an immunologic mechanism, the skin sensitizing antibody. Inhalants, foods, drugs and serums are exciting allergens. The second or infective type is suspected when the attacks are preceded by colds and paranasal sinus complications. Dental infection, especially about the antra, are not an uncommon source of infective asthma. I recognize that this is a classification that has recently been attacked by Waldbott,[1] but for practical working purposes, it is very useful.

The following case is of interest from the standpoint of a proper history in determining the etiologic factor.

A male, age 50, employed as a baker for twenty-two years was referred for study because of asthmatic attacks of increasing severity. The personal medical history in this case was negative. He remembered occasional mild chest discomfort, perhaps with a little wheezing but he was never inconvenienced and never lost time from his work, nor did he lose any sleep. There was no seasonal aggravation. During the last year he had attacks of increasing severity, some requiring adrenalin. During this time his job was no different than always. There was, of course, a fair amount of flour in his environment but he did not consider himself worse in the bakery than at home. However during questioning he recalled a significant incident. One morning at work in the bakery he dropped a sack of flour while helping to unload a truck. The sack burst as it hit the ground covering him with a cloud of flour. He immediately developed a violent asthmatic attack. Here was the trigger mechanism that threw him out of balance. For years he had moderate exposure to flour during the course of his employment. He was in a state of immunologic balance until he was overwhelmed by a tremendous dose of an allergen and he has been out of balance since. He had a terrific skin reaction to wheat flour. After reluctantly changing his occupation he became free of attacks.

THE PHYSICAL EXAMINATION

Unless the patient is seen during an attack the physical examination may be unrevealing. The characteristic feature of long standing severe asthma is the emphysematous chest. This is evidence of irreversible pulmonary changes. A complete physical examination is mandatory to help establish a diagnosis, to note associated diseases or disabilities, and to find any evidence of focal infection. An evaluation of these factors has a definite bearing on the prognosis and the treatment. Foci that need particular attention are the teeth, sinuses and pharyngeal lymphatic tissue.

LABORATORY AIDS

Routine blood counts and urine examinations should be made. In uncomplicated cases, these are within normal limits. An abnormal urine may suggest further renal studies to rule out a uremic type of asthma. Marked eosinophilia and/or leucocytosis will likewise necessitate more definite study. Transillumination of the sinuses is a worthwhile procedure. A chest film should be routine; sinus x-ray may be necessary in selected cases.

THE SKIN TEST

Arguments about the relative merits of scratch compared with intradermal testing have simmered down. The technic of each has varied from the simplest to the most elaborate setups. One's choice depends upon experience and convenience. Properly conducted intradermal testing is safe. The margin of safety will increase with the standardization of extracts. When beginning tests on a new patient it is well to limit the number at one sitting to six or eight; never more than twelve. Allergens that are strongly suspected from the history are best not all included in one series. The technic of the test itself is important. The amount injected intradermally should be no more than that needed to produce a noticeable tiny bleb. This theoretically is less than 1/50 of a cubic centimeter. With good technic, uniform minimal injections can be made in the top layer of the skin. False positives are thus reduced to a minimum. The method is relatively painless and one avoids the danger of mass reaction due to a multiple positive reaction of excessive size. Once the skin sensitivity of the patient is known larger groups usually eighteen, can be done, particularly when foods make up all or most of the set.

As a part of routine skin testing, foods should be included. The likes and dislikes of the patient may be consulted. Certainly foods which never enter into the diet should not be included. Many articles of food contain ingredients with which the patient is unfamiliar, and may think he is not eating. For example —coca cola contains among other things, cin-

1. Waldbott, George L.: Ann. Internal Medicine, 30:863 (June 1947).

namon, lime juice and nutmeg. Canned tomato soup contains butter, onions and flour.

A patient with strict seasonal asthma may not need food tests. However, a similar case may benefit by identification of positive reacting foods so that they may be eliminated during the season of attacks and aid in restoring the allergic balance. Certainly the limitation of tests is an advantage in uncooperative children, many of whom have been spoiled by their invalidism.

PREVENTION

The management of asthma divides itself into two phases. *Prophylactic treatment* involves the elimination of as many offending environmental allergens as possible, attention to associated diseases particularly involving the respiratory tract, and hyposensitization with inhalant allergens from which the individual cannot fully escape. These are most commonly seasonal pollens, molds, and dust. Careful management along these lines gives a high ratio of satisfactory results. There still remains a fair proportion of patients who fail to respond. The factors responsible may be (1) inadequate study of the case, (2) irreversible pulmonary changes or (3) pure "cussedness" on the part of the patient.

A male, age 23, a hospital resident, complained of perennial vasomotor rhinitis for eighteen months, during the last four of which he was having nocturnal asthma. This was not a pollen season. Routine skin testing was started before an adequate history was obtained. In the first group of tests he had a plus-three reaction to dust and dog hair. It was then learned that for over two years he had a dog with him wherever he went. The dog slept on the bed with him and there was therefore no doubt of the etiologic relationship. When advised that his cure might result from his parting company with the dog, the doctor answered that he would rather have his asthma than part with his dog.

PHYSIOLOGY OF THE ATTACK[2]

The asthmatic paroxysm is caused by spasm of the smooth muscles of the smaller bronchioles. Edema is also present. Which comes first matters little, since in the full blown attack both are present. As a result of these changes, alveolar ventilation is impaired and some portions of the lung may be completely cut off from their air supply. Carbon dioxide accumulates in these spaces, with a corresponding low oxygen saturation of the blood. The amount of blood carbon dioxide is increased and a gaseous acidosis results. The excess carbon dioxide and the insufficient oxygen in the blood together stimulate the respiratory center so that hyperpnea results. Since the bronchioles normally narrow during expiration, and they are now choked off still farther with spasm and edema, great muscular effort is needed to cause the necessary gaseous interchange. All the respiratory and accessory respiratory muscles come into play and contract with great force. The intrapulmonary pressure builds up to a high level and the trapped air is forced through the contracted bronchioles with a wheezing sound. Because of the difficulty of this prolonged expiratory phase, normal deflation is not effective before the next inspiration starts. The lungs therefore remain in an inspiratory position with a large amount of residual air. The tidal air is small and corresponds to the vital capacity at the moment. Since the subject is already exerting the greatest possible inspiratory and expiratory effort there is obviously no complemental or supplemental air. Muscular effort is extreme, yet there is practically no interchange of air. An anoxic type of anoxia results.

TREATMENT

The treatment of a severe attack of asthma or status asthmaticus must be approached on the basis of its physiology. Therapy must be directed first against the spasm and edema of the bronchioles, second to the release of retained secretions and third to the correction of impending or existing anoxia.

The avalanche of much heralded drugs and mechanical devices has not affected the basic principles of the management of an asthmatic attack. *Epinephrine* by the subcutaneous route is the drug par excellence for any attack regardless of its severity. Epinephrine and its related substances *ephedrine*[3] act by stimulation of the sympathetic portion of the autonomic nervous system, increasing its tone and producing vasoconstriction. This results in pallor and shrinkage of the mucous membrane on local application. These drugs are also antagonistic to the parasympathetics. By stimulating the sympathetic fibers in the bronchi, they produce bronchial dilation and overcome the opposing vagus pull responsible for bronchospasm. Relief of asthma is further accomplished by shrinkage of bronchial mucosa due to vasoconstriction of the arterioles.

For the sake of convenience, nebulization of epinephrine in 1 to 100 dilution may be used

2. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice*, (ed. 4) 1945, Williams & Wilkins Co., Baltimore, pp 366-368.
3. Tuft, L.: *Clinical Allergy* (ed. 1) 1937, Saunders Co., Philadelphia, p. 112.

for mild attacks and for "impending" attacks. However its very ease of administration frequently becomes one of its objectionable features. Patients have a habit of overdosing themselves with it and often use it when oral medication might do as well. One-to-a-thousand epinephrine given in fractional doses remains the best way to start the treatment of an asthmatic attack. Two to six minus of a clear solution, given subcutaneously at ten to twenty minute intervals will stop most ordinary attacks of asthma. With this procedure, the side reaction of adrenalin will be minimal. A few doses of phenobarbital will readily overcome any such symptoms that might occur. If relief is not forthcoming within a two hour period one may consider that the attack has passed to the next stage of severity and that supplementary measures have become necessary. It is at this point that the intravenous administration of *aminophyllin*[4] finds its greatest usefulness. A 10 cubic centimeter solution containing 250 milligrams (3¾ grains) given slowly, often produces a dramatic response. Dyspnea eases rapidly, the respiratory rate becomes almost normal, the color improves and the patient is generally much more comfortable. Wheezing may still persist, and it is at this point that a repetition of a course of adrenalin as previously described terminates the attack. Following this, the intramuscular administration of a cubic centimeter of epinephrine in oil (1 to 500) at 8 to 12 hour intervals is usually sufficient to keep the patient under control. Small doses of epinephrine subcutaneously may again be needed during this interval, but in the average case its frequency is reduced as the attack subsides. *Ammonium chloride* and *iodides* may now be given in an attempt to facilitate the removal of tenacious secretions from the bronchial tree.

Any patient who fails to respond to these rather simple measures, may be considered in status asthmaticus. In my experience there has been no success in treating such cases at home or in a hotel room. I insist upon hospitalization. At about this time the patient, his family and attendants, and frequently the physician are frantic. Simple removal of the sick asthmatic to a hospital may be sufficient to modify that attack. Hospital wards and rooms are normally free of the allergens to which the patient is sensitive. Once the patient is settled in the hospital environment, the anxious family removed and the patient surrounded by the confidence that emanates from an efficient nursing staff, he becomes emotionally more stable and the repetition of the previously mentioned routine of epinephrine, aminophyllin and epinephrine in oil often becomes effective. I oppose the common practice of overloading the patient with drugs. I have seen many severe asthmatics sicker from their treatment than from the attack itself. In time, a large proportion of patients with severe asthma will respond to these simple measures. When they do not come out rapidly, one should anticipate the occurrence of anoxia. Oxygen by tent or BLB mask may be given by intermittent or continuous administration depending upon the benefits obtained. Some cases do better with helium and oxygen[5] in a 20 to 80 ratio. This is best given intermittently by mask. The light helium molecule is said to carry the oxygen into the alveoli with a minimum of respiratory effort. More recently[6] oxygen has been administered intravenously in severe bronchial asthma.

As a severe attack of asthma may run a number of days, some attention must be given to the fluid balance of the patient. A satisfactory water balance must be obtained. Ordinarily the oral intake is sufficient. Depending upon the severity of the attack it may have to be supplemented or replaced by intravenous fluids. Five per cent glucose with normal saline solution make up a satisfactory mixture. Two litres a day are usually enough to insure proper renal flow. Unger[7] advocates the administration of aminophyllin by slow intravenous drip in alternate mixtures of glucose and saline.

Morphine is contraindicated in asthma. Of two deaths that I have seen in patients with status asthmaticus, one was undoubtedly due

4. Hyman, Charles: Medical Record, 150:279 (October 1939).
5. Barach, Alvin L.: Ann. Internal Medicine, 9:739 (May 1935).
6. Markow, Harry, *et al.*: Annals of Internal Medicine, 32:607 (October 1948).
7. Unger, L., and Godsall, R. J.: Annals of Allergy, 5:196 (February 1947).

to morphine. Consider a patient in respiratory distress, hyperpneic, anoxic and full of tenacious secretions that he is trying to expel by cough. Give him a dose of morphine and what happens? The respiratory rate may be cut in half and the anoxia increased in proportion. The cough reflex may be abolished or certainly diminished by the morphine and the patient is unable to rid himself of the thick secretions plugging the bronchi. This further increases the anoxic state. For similar reasons I have very little use for other opiates. I am likewise opposed to demerol. In addition the danger of addiction is great. Polonio[8] reported 32 cases of addiction and five deaths due to demerol. In this stage of asthma an adequate dose of a barbiturate should be sufficient for relaxation and sleep.

Antihistaminics have but a limited, if any, usefulness in bronchial asthma. *Hydryllin* a combination of aminophyllin and an antihistaminic, diphenhydramine, has proved useful in mild to moderate asthma. Perhaps there is some synergistic effect between these two drugs.

COMPLICATIONS

The irreversible changes that take place with chronic asthma are well known and need no repetition here. It is important to bear in mind some complications that may take place during severe acute asthma.

A male, age 66, was a known asthmatic for over twenty years. He was always in some degree of asthma but usually suffered seasonal exacerbation in June and July. As usual this past summer he developed his severe attack. However after three weeks of suffering, and the use of all the measures that usually gave him relief, he was in worse condition than ever. Dyspnea was severe, cyanosis was appearing and his cough was uncontrollable. He was referred by his physician for treatment of status asthmaticus. Examination revealed an orthopneic, cyanotic and restless patient who would not remain in the oxygen tent. Asthmatic wheezes were heard over the left chest. Breath sounds were absent over the entire right lung, the right hemithorax was hyperresonant and it was immediately apparent that he was suffering not so much from his asthma as he was from a right spontaneous pneumothorax. Paracentesis with removal of 1500 cubic centimeters of air from the pleural space brought about complete expansion of the lung and a normal negative pressure. Relief was instantaneous.

Peterson[9] reports a fatal case of bronchial asthma complicated by mediastinal and subcutaneous emphysema. Fractured ribs have also been reported as occurring during the violent paroxysms of cough. Atelectasis, either lobar or segmental, must be watched for in protracted asthma.

I have presented what I consider a practical working concept of bronchial asthma. Perhaps in our time research will yield a substance common to all allergens,——food, pollen, mold or bacteria. When that Utopian moment arrives, desensitization will have reached perfection. Until then, our treatment of bronchial asthma as well as all allergic states will depend upon a full knowledge of the etiology and the pathologic physiology of the asthmatic attack.

2807 Pacific Avenue

DISCUSSION

DR. LEWIS W. BROWN, Newark: Dr. Hyman's case histories were examples of pitfalls in diagnosis and we could all add many of our own to swell this group. I just recently autopsied a 2-year old child, who was treated as an asthmatic, and who showed all of the classical anatomic findings of status thymico lymphaticus including a thymus weighing 56 Grams. And this child's asthma was considered intractable because it did not respond to adrenalin.

I should like to add a few remarks on laboratory aids in diagnosis and treatment of bronchial asthma.

The sedimentation rate is a valuable screening test in looking for cases complicated by tissue infection. The only caution in the use of this test is to consider a 20 millimeter fall in 60 minutes as usual rather than the 8 to 12 millimeter fall usually considered normal.

Vital capacity determinations help determine the degree to which the residual air is handicapping the patient and gives one a figure to emphasize to the patient in restricting his activity. It also gives a good index in following the progress of treatment in many cases.

Sputum examinations could be done more often with helpful results. Even gross examination gives important information. Smears for eosinophiles help in classifying cases and smears and cultures for bacterial organisms aid in selecting antibiotic drugs and in deciding on the possible use of autogenous vaccines. And today we must study the cytology of the sputum by appropriate staining measures if we are to be thorough in the diagnosis of cases who might possibly have cancer.

8. Polonio, P.: Lancet 1:592 (June 1947).
9. Peterson, Heyes: Journal of Allergy, 18:413 (November 1947).

In discussing the treatment of the asthma attack, Dr. Hyman mentioned all of the drugs and measures that one would need: epinephrine, ephedrine, aminophyllin, the iodides, phenobarbital, glucose, saline and oxygen. What more would one really need? A choice of sedatives possibly such as chloral, bromides or paraldehyde. But none of these drugs is new and I think it is of importance that, in reading a paper on this subject, Dr. Hyman feels that he needs only drugs which have been in the pharmacopoeia for many years. I feel as does Dr. Hyman that the successful practical management of the patient with bronchial asthma can be accomplished by intelligent use of those drugs which we now have to supplement the well established principles of allergic management.

Two drugs which I would like to mention because I use them even though they are often condemned in allergy are opiates and acetylsalicylic acid. Morphine in 1/12 grain doses, or demerol in 25 to 50 milligram doses may be used in combination with adrenalin in the same hypodermic injection with benefit in many cases of acute asthma. Used in this manner it is not dangerous to the patient. In the patient not sensitive to aspirin, acetylsalicylic acid (when combined with ephedrine) will be most helpful to many mild persistent asthmatics. And the danger of inducing aspirin sensitivity is very remote.

Of the antihistaminics, benadryl for its sedative effect is about the only one I find a real use for in bronchial asthma.

The principles of allergic control, environmental and dietary and of hyposensitization are well recognized. I would suggest only a wider use of antigenous vaccines in this category. In reviewing my own experience in the management of asthmatics I find that the following procedures have been most neglected:

First, the complete survey of the patient's home, collecting samples for testing and giving first hand aid in establishing an environment free from offending allergens.

Second, better dietary control of the asthmatic patient to effect not only elimination of foods to which he is allergic but to assure the patient of a well balanced palatable diet containing all the essentials for growth and health.

Third, more frequent use of remedial exercises to overcome the distention of the lungs and the immobility of the lower thorax and diaphragm thus increasing vital capacity and a better ventilated patient.

I have benefited very much from reading and hearing Dr. Hyman's paper. I congratulate him on his practical use of the measures he suggests.

MANAGEMENT OF ACNE VULGARIS

S. J. FANBURG, M.D., Newark, N. J.

Acne vulgaris is primarily a disease of adolescence. During these formative years, the physical and psychic attributes of the individual undergo tremendous strains. The changes associated with growth and development have a profound effect upon the emotional outlook. The awkwardness of gait, the change of voice, the consciousness of the sexual instinct are some of the manifestations of the adolescent period. When to these changes are added outbreaks of papules and comedones and a generally unattractive skin, emotional disturbances may arise. Such lesions may lead to a feeling of inferiority and a tendency to withdraw from the usual gregarious pursuits of the teen-ager. These activities are necessary for the wholesome development of the individual. They are the foundation stones of what he will be and do in adult life.

When acne lesions develop, the adolescent becomes ashamed of being seen in public, withdraws from athletic activities, becomes embroiled in domestic arguments with parents and siblings, and otherwise suffers severe trauma. This in turn may aggravate a preexisting acne. Thus a vicious cycle is established.

Sulzberger and Zaidens [1] believe that "there is probably no single disease which causes more psychic trauma, more maladjusments between parents and children, more general insecurity and feelings of inferiority and greater sums of psychic suffering than does acne vulgaris."

Too frequently the adolescent is told by the family doctor that the acne is of no importance and that he will outgrow it without treatment. It is, however, the opinion of dermatologists that this disease should be treated as soon as it starts. Early treatment may prevent permanent scars, will keep the condition under control, and will minimize psychic

1. Sulzberger, M. and Zaidens, S.: Medical Clinics of North America, 32:669 (May 1948).

trauma. A cure in the early stage cannot always be accomplished, but much may be done to alleviate and control the symptoms, and the resultant emotional tension.

The acne process begins during, just before, or just after puberty. Site of the primary lesion is the sebaceous gland. The primary lesion is the comedone. Without the comedone there is no acne vulgaris. The skin disturbance is made worse by emotional turmoil, certain foods (such as chocolate and nuts) and drugs such as iodides and bromides. The fact that acne is usually associated with puberty gives rise to the assumption that sex hormones are somehow involved. And it seems reasonable to assume that a sudden or even a gradual appearance of androgens or estrogens in the blood stream may stimulate the sebaceous glands to an overactivity and produce a hyperkeratosis of the follicles. This is the pathology of acne: a hyperkeratosis of the follicles and an increased sebaceous secretion. The openings of the glands become plugged from the increased keratin production. Chemical oxidation changes the color to black and a comedone results.

In the treatment of acne vulgaris hormones have had a trial with equivocal results. Theoretically, the androgens and estrogens should be helpful, but in my opinion they are dangerous. Side effects and glandular imbalances may be produced which were better avoided. Small doses of thyroid in suitable cases are useful. Internal medication should be used whenever there are concomitant disturbances calling for them. For example, secondary anemia and constipation should be corrected if found. From my own observations, it appears that nuts, chocolate, fried food, and iodized table salt do produce exacerbations and should be avoided. Vitamin A in large doses should be administered over a period of several months. Oher vitamins, however, should be given with it to avoid imbalance.

In the topical treatment of acne vulgaris it has been found that resorcin and sulfur have stood the test of time. Object of local therapy is to produce a mild exfoliation of the superficial layers of the epidermis and to reduce the activity of the sebaceous glands. Resorcin and sulfur, together or alone, act as keratolytics and keratoplastics, according to the concentration used. It is best to begin with 2 per cent resorcin and 5 per cent sulfur in a suitable vehicle. If the skin shows no irritation from this mild application, the strength of these agents may be increased to get an adequate amount of exfoliation. When the skin becomes dry, the comedones come closer to the surface and are cast off. When dryness becomes excessive, keratolytics may be temporarily withheld.

Up to the age of 14 or 15 ultra violet light may be used to hasten the process of exfoliation. In older patients, roentgen therapy under proper control is used to good advantage with excellent results in 90 per cent of acne cases. It is a common misconception that x-ray causes scarring. The acne lesions themselves, however, produce scars, with or without treatment. The sooner treatment is begun, the fewer acne lesions will result, and the less scarring will be produced.

An excellent aid in topical treatment is a preparation which incorporates resorcin and sulfur in the form of a cosmetic base. This is applied to the skin in the daytime. It has exceptional covering properties and the medications act over a long period of time. It is a great boost to the morale of the acne vulgaris patient, as the lesions can be almost completely hidden. The product[2] consists of a number of ingredients blended to produce a flesh-colored cake, and is put up in the form of an easily carried compact.

The formula contains isopropyl stearate 32 per cent; lecithin 1 per cent; lanolin 3 per cent; cetyl alcohol 2 per cent; titanium dioxide 42 per cent; kaolin 6 per cent; ceresin 4 per cent; resorcin 2 per cent; and sulfur 8 per cent.

I have treated a series of thirty-five patients with this preparation with satisfactory cosmetic results. A case typical of this group illustrates the usefulness of this covering medication:

A 14 year old girl had a clear skin until six months previous to the time she was first seen. She had always been a cheerful, pleasant girl who

2. Cosmedicake No. 2 (medicated). Made by Ronjo Products Corporation, 307 Fifth Avenue, New York City.

made friends easily and got along well with her brothers and sisters at home. With the onset of an eruption of papules, pustules, comedones, and an oily skin, her personality underwent a striking change. She became introspective and quarrelsome. She avoided her schoolgirl companions and spent most of her spare time looking in mirrors and attempting inexpertly to express blackheads. As a result of these manipulations she had produced many traumatic lesions. She was given mild exfoliative doses of ultra violet light, and a resorcin and sulfur mixture was prescribed for nighttime use. A covering medicated base for use in the daytime was prescribed and its use insisted upon on account of the mental state of the patient. It took several months to get the acne under complete control, but there was an almost immediate reversal to normal in the patient's personality. When she found how easily and completely she could conceal her "blemishes", she again became the cheerful pleasant girl who was sought after by her friends.

A proper cosmetic preparation facilitates the important early, active treatment of acne vulgaris. When cooperation is secured, much can be done to improve the mental and physical condition of the patient. In occasional cases where excessive dryness results from the medicated covering preparation, the psychologic benefit may be maintained by substituting temporarily a similar formula[3] with the keratolytics omitted. Such a product has several advantages. The patient with facial lesions requires considerable support for the psychic trauma created by the cosmetic symptoms, and a form of therapy that provides such psychologic support is most desirable. Also, a preparation of this type avoids the obvious "medicated" look associated with most prescriptions for acne vulgaris, seborrhea, and related skin conditions. Since this preparation is available in both medicated and non-medicated forms, the desired condition of the skin can be maintained by alternating the keratolytic or medicated form with the non-keratolytic or non-medicated form. Afer the desired course of therapy has been completed, the patient can be continued on the same prescription utilizing a hypoallergenic cosmetic to cover any residual marks.

31 Lincoln Park

NEW JERSEY TRUDEAU SOCIETY

The New Jersey Trudeau Society, which is the Medical Section of the New Jersey Tuberculosis League, held its second annual business meeting in Trenton on October 18, 1949. Dr. Harold S. Hatch, Morristown, was re-elected president; Dr. Martin H. Collier, Camden, vice-president; Dr. John E. Runnells, Scotch Plains, secretary-treasurer.

Eligible for membership are physicians licensed to practice medicine in the State of New Jersey, who have shown particular interest in tuberculosis and other thoracic diseases for a period of at least three years and who are members in good standing of the American Trudeau Society, which is the Medical Section of the National Tuberculosis Association.

The purpose of the New Jersey Trudeau Society is to furnish medical leadership to the State League and its twenty-one affiliated county associations and to further clinical, epidemiological and other scientific studies in tuberculosis and other thoracic conditions, and to promote professional and social relations of the members and cooperate with other official and unofficial organizations interested in the control of tuberculosis.

CORRECTION

The phrase "500 millimeters" which appeared on page 571 and again on page 572 of the December 1949 Journal should read "500 milliliters". This refers to the article on "Selection of Blood Donors".

COUNCIL ON INDUSTRIAL HEALTH

Next meeting of the Council on Industrial Health will be at the Roosevelt Hotel in New York City on February 20 and 21.

3. Cosmedicake No. 1 (non-medicated). Made by Ronjo Products Corporation, 307 Fifth Avenue, New York City.

THE CHOICE OF A SUTURE MATERIAL *

WITH SUTURE STATISTICS IN NEW JERSEY

Stuart Z. Hawkes, M.D., Newark, N. J.

Sutures and ligatures have been employed in surgery since prehistoric times. Rawhide thongs were used among the Indians and Egyptians crudely to approximate a wound. However, the infection of the wound often ruined attempts at closure. Many wounds were closed by cauterization and many amputations were completed with the actual cautery or with boiling oil. Heat cauterization sterilized the wound and controlled bleeding.

With the advent of Listerian surgery, catgut sutures were tried, but gave trouble because of faulty sterilization and lack of standardization of suture sizes. For these reasons catgut, at times, caused serious infection and could not be depended upon to hold the wound for a specific time. Later, non-absorbable sutures of silk were advocated by Halsted. He enjoined a meticulous technic with gentle handling, careful hemostasis and interrupted fine sutures for wound closure. Because of wound infections, these silk sutures might be extruded from the wound for long periods postoperatively. Thus many surgeons became wary of all non-absorbable sutures.

In 1934 Babcock[1] led a reawakening of interest in metallic sutures by reports on the advantages of stainless steel. Gold, silver, copper and bronze had all been used in surgery. Sims closed his first vesico-vaginal fistula (in 1849) on the thirtieth attempt by using silver wire. Vitallium and tantalum have been added to stainless steel recently, each having its own indications. Metallic materials have the advantage of marked tensile strength for their size. For example, tantalum wire, 0.003 inches in diameter, has a strength equal to Number 60 catgut. They do not tarnish, discolor or cause irritation. In a wound, they produce practically no tissue reaction. They have been recommended in the repair of tendons, in herniorrhaphies, and in gastro-intestinal anastomoses. Recently wire mesh has been advocated to bridge the gap in hernial fascia defects.

TYPES OF MATERIAL

Two general types of suture material are available: absorbable and non-absorbable. Surgical gut, kangaroo tendon, and fascial sutures are examples of the former; silkworm gut, horsehair, dermol, silk of animal origin, linen and cotton of vegetable origin, nylon (a synthetic derivative) and metallic sutures, are non-absorbable sutures. Each surgeon has his preference, but does not depend entirely on one to the exclusion of all others. Fewer wound disruptions, fewer postoperative hernias and fewer recurrent hernias occur when non-absorbable sutures are used. For these reasons, non-absorbable sutures are of interest to most surgeons. However, they cannot be used under all circumstances and have limitations. When the perfect ligature is produced this discussion will cease. Such a ligature must conform to the following requirements:

1. It must be free from bacteria.
2. The material must not act as a culture medium for the growth of bacteria which may enter the wound.
3. The material should withstand sterilization without destroying its efficiency.
4. It should hold the edges of the wound in position until a union of sufficient strength has been established, regardless of the "lag period".
5. After it has served its purpose it must be completely absorbed. If non-absorbable, its presence in the tissues must not cause reaction and remain completely inert.
6. The material must not cause any tissue reaction which might prolong the "lag period". If possible, it should hasten this period and decrease the phase of fibroplasia.
7. It should be non-capillary.
8. It must have sufficient coefficiency of friction so that a knot may be tied with complete safety.
9. It must be pliable and easy to handle.

* (Read before the Practitioners' Club, Newark, N. J., March 31, 1949.)

1. Babcock, W. W.: Journal of the American Medical Association, 102:1756 (1934).

Until such time as the ideal suture material has been found, the surgeon must depend upon his operative technic to minimize the deleterious effects of the suture on the healing of a wound. To use a large size surgical gut when a small size will suffice is asking for complications. The same can be said of any of the other materials. The surgeon should give considerable thought to the making and closing of an incision. The layers of the abdominal wall should be incised cleanly and with sharp instruments. Gentleness in the handling of tissues includes the selection of correct instruments. For hemostasis, small, straight bladed, non-toothed clamps are ideal. The hemostatic bite should include the bleeder only, or, if unavoidable, only a minimum of surrounding tissue. Vitamin C pre-operatively may make it unnecessary to apply forceps to small bleeders. The larger bleeders are divided and the portion of the vessel distal to the ligature is excised. If sponging is needed, the wound is gently blotted, never scraped. Sutures in the subcutaneous fat should be avoided, especially catgut, except to suture the superficial fascia. The fascia layer of abdominal incisions should be incised parallel with the direction of its fibres. If it becomes necessary to clamp fascia, we use a non-crushing forceps such as an Allis, never a hemostat or Kocher type mouse toothed forcep. Crushed tissue becomes devitalized and interferes with healing. We use eyeless atraumatic needles where possible or, at least, small needles.

SUTURE TECHNIC

The function of the suture is to hold the tissue together artificially during the "lag period" and until the wound has its original strength due to fibroplastic infiltration. This period normally lasts from 10 to 14 days but may be much longer. A suture is a foreign body. Hence, use the least amount and the smallest size consistent with the holding power of the tensile strength of the tissue to which it is applied. A continuous row of sutures is stronger than a corresponding line of interrupted stitches because tension is evenly distributed and only two knots are present. On the other hand, the entire structure of the wound is jeopardized when a break occurs anywhere along the continuous suture line. In the event of suppuration, a continuous row gives more trouble than a wound sutured with interrupted stitches. In a continuous suture line, more material is utilized which produces greater tissue response. Accurate approximation of the tissues and avoidance of "dead spaces" are essential for prompt healing. Approximation should be done without puckering, tension, or undue laxity. Wide separation of tissues creates "dead spaces", which soon become filled with exudates; these may delay healing or predispose to infection. When tissues are sutured under tension the result is tearing and strangulation. These complications are serious, especially when hollow organs are involved.

It is questionable just how much progress has been made since the days of Ambrose Pare who in the 16th century thoroughly appreciated the difference in healing between the gently cleansed wound and the wound cauterized in boiling oil. Too few surgeons practice and teach the important surgical principles of wound healing. Fortunate is he who was painstakingly indoctrinated with those minute detailed principles of surgical technic which make excellent wound healing an expected result. At times the busy young surgeon has the knowledge but lacks the patience and practical wisdom necessary for its proper application. Too many have been surgically reared on a "routine closure", and are able to "get by" with careless and impractical methods because of the remarkable ability of living tissue to withstand trauma. Ledbetter[2] says, "Wound healing is a natural cellular growth and if the wound is not handicapped by necrotic tissue, foreign bodies, strangulating ligatures, blood clots, et cetera, it will heal spontaneously."

Much of the recent literature has wrongly emphasized the advantage of one type of suture material over the other without regard to the importance of gentleness in handling tissue, well placed incisions made with sharp

2. Ledbetter, S. L., Jr.: J. M. A. Alabama, 12:46 (August 1942).

blades, careful gentle sponging, adequate length of incision (necessitating only moderate retraction), wide separation of structures, careful hemostasis, and correct instruments and needles. Non-absorbable sutures cause minimum tissue reaction. The size of the suture, attention to minutest details in placing it, and wound toilet are more important *per se* than the type of suture used.

Word and Brock,[3] writing from the surgical service at Camp Shelby, during the war years, stated their experience in this connection. One of the authors was admittedly well trained in the use of fine suture material, gentle handling of tissue, ligation of vessels with minimum surrounding tissue, meticulous hemostasis and the use of interrupted sutures before entering service. The other's interest was "largely gynecology and a great many of his surgical principles were formulated while removing large fibroids with large sutures and taking large bites of tissue with large needles". On occasion, each would perform one side of a bilateral hernia together, using identical suture material. On these cases, at any time during the postoperative period, one could stand at the foot of the patient's bed with the dressings removed and tell at a glance the surgeon responsible for each wound. After switching to cotton, with concentration on suture technic and careful handling of the tissues, the wound reaction was so improved by one of them that it was later impossible to distinguish the wounds. The wounds of the meticulous surgeon were only slightly improved; the wounds of the "traumatic surgeon" were greatly improved.

The importance of the careful placing of sutures and proper reapproximation of divided structures was dramatically demonstrated by Stevenson and Reid[4] in their experiment in which the abdominal wounds of dogs were sutured by the traumatic and atraumatic method. Both wounds were opened in five days. In one dog the wound was healed with minimum reaction. In the other, many of the sutures had sloughed out following pressure necrosis.

WOUND HEALING

In an uncomplicated wound, the process of repair (or healing *per primum)* consists of three phases. First reaction is the outpouring of an exudate consisting of plasma, blood cells and liberated fibrin which fills and agglutinates the gap in the wound. This is the "lag period" which lasts from four to six days. If the wound is closed with an aseptic, atraumatic and hemostatic technic and the nutritional status is normal, the amount of exudate is minimal.

The second phase begins on the fourth to sixth day with the appearance of fibroblasts and new vascular buds. These multiply rapidly to fill the gap and to restore the continuity of the wound edges. The tensile strength of a healing wound is a function of the multiplication and maturation of the fibroblasts. The velocity of the growth starts abruptly at a maximum and progressively diminishes in rate until the end of the phase of the fibroplasia on the tenth to fourteenth day.

Final phase is the formation of a firm adult fibrous tissue or scar.

The rate and extent of the length of the "lag period" and phase of fibroplasia varies according to age and nutritional status of the patient, presence of associated chronic diseases, extent of the wound, suture material, hemostasis, tissue trauma and infection. Any one, or combination of these may ultimately determine the fate of the wound. The basic and essential requirements for normal healing of a wound are:

1. A state of positive nitrogen balance.
2. A normal fluid and electrolyte balance.
3. Adequate concentration of vitamin C.

Since wound healing is a biologic phenomenon conforming to the laws of growth, any deficiency in the protein content of the body will affect the rate of repair of tissue after injury. Abnormally low plasma protein has a specific effect by retarding the proliferation of the fibroblasts, thus prolonging the phase of fibroplasia. Tissue edema resulting from hypoproteinemia seriously interferes with wound healing. The severity of the edema parallels the extent of plasma protein depletion; especially when the albumin factor is decreased to a greater proportion than the globulin. Thompson has shown that abdominal wound disruption occurred in 72 per cent of dogs operated on in the presence of hypoproteinemia. Edema of the stoma and the intes-

3. Word, B., and Brock, C. E.: American Journal of Surgery, 63:371 (1944).
4. Stevenson, J., and Reid, M.: American Journal of Surgery, 46:442 (1939).

tinal wall after an anastomosis inhibits intestinal motility. Ascorbic acid is an essential requirement for the production and maintenance of intracellular cement, which is composed largely of collagen. Wofler demonstrated that human subjects on prolonged ascorbic acid depletion exhibit about 50 per cent diminution in tensile strength of healing wounds. These subjects also exhibit a recognizable lack of collagen and reticulum in their healing wounds.

Sulfa drugs and penicillin are not entirely effective in combating wound infection. The application of sound surgical principles is still the most important method of preventing infection. Sulfa is best controlled and a blood level best maintained when the drug is administered by mouth, or secondly by intravenous administration. The rate of absorption after topical administration whether on mucous membranes or mesodermal structures is inconstant and unpredictable. When sulfa is dusted in a wound it increases the "lag period" by producing a wet wound due to the outpouring of plasma and thus increases the chance of infection or disruption. In the peritoneal cavity, it increases adhesions although evenly distributed.

SUTURE STATISTICS IN NEW JERSEY

In the fall of 1940 I became interested in non-absorbable sutures. It seemed that better surgery with more meticulous technic was necessary to use them and that focusing on this factor, in itself, would improve my surgery. A shift to cotton was made in clean closures and in selected cases such as breast, thyroid and hernias. When cotton was first advocated by Meade and Ochsner[5] it was thought to be an all-purpose suture which could be used in dirty or clean cases without thought of postoperative draining sinuses. It was found that this was not true, but that it had the widest application for wound closure.

To study the opinions of a large group of surgeons, a questionnaire was sent to all members of the American College of Surgeons in New Jersey and also to the members of the Society of Surgeons of New Jersey. Four hundred and sixty-five surgeons received questionnaires and 303 replied. This number was divided into smaller groups by specialties for analysis.

This state seemed interesting to canvass in view of the fact that it lies between two large medical centers.

Its surgeons have been trained in many widely separated medical centers, in undergraduate and postgraduate teaching. These statistics therefore represent a wide cross-section of opinion, and possibly a genuine nationwide trend, inasmuch as they do not, to any extent, reflect the doctrine of any one training center.

Three questions were asked: (1) Have you changed suture technic in the last five years? (2) What are your preferences for wound closure?; and (3) In abdominal wound closure, what are your preferences for each layer?. The answers are discussed below and displayed in the tables bearing the corresponding numbers.

1—Have you changed suture technic recently (5 years)

Answers to this question (Table 1A) showed that 177 (60 per cent) had changed their suture technic in the past five years. The actual figure should be even higher as some surgeons commented that a shift had been made more than five years ago. Specialists in general surgery and gynecology made up the greater proportion of those shifting, while the others, on the whole, were more satisfied with their long standing choice.

TABLE 1A

HAVE CHANGED SUTURE TECHNIC	Yes	No	No-Ans.
Surgical Subspecialties			
Gen. Surgery	78	37	0
Gen. Surg.—Gynecology	46	23	0
Gynecology	26	11	0
Orthopedics	10	10	0
Ophthalmology	5	13	0
E.N.T.	1	10	0
Miscellaneous*	3	4	0
E.E.N.T.	2	1	3
Urology	2	3	0
Thoracic	3	1	0
Plastic	1	2	0
Neurosurgery	0	3	0
Total	177	118	3

* Denotes several subspecialties of surgery performed.

Of the 177 who had made a change (Table 1B) almost all (164) were using smaller sizes,

5. Meade, W. H., and Ochsner, A.: Surgery, 7:485 (1940).

no matter what the material. A large number (59) had changed over to non-absorbable sutures. Most of these had concentrated on cotton and wire. This figure represents a shift of 20 per cent, (or one in five surgeons) to a non-absorbable material in the past five years. It indicates a definite trend, most marked among general and pelvic surgeons.

TABLE 1B

HAVE CHANGED SUTURE TECHNIC		177
Smaller Sutures		164
Absorb. to Non-Absorb.		59
Cotton	32	
Wire	18	
Silk	9	
Non-Absorb. to Absorb.		5
Silk	2	
Cotton	1	
Back	2	
Non-Absorb. to Non-Absorb.		4
Silk to Cotton	2	
Cotton and Silk to Wire	2	
Cotton added		1

2—"I believe wound closures best performed by (type of suture material)"

Most of those answering this question (Table 2) preferred a surgical gut *absorbable* suture for wound closure. Almost half of the responding surgeons (120) depended on one of the *non-absorbable* groups with silk and cotton about equally preferred. Of the subgroups, the general surgeon was proportionately the greatest exponent of absorable sutures.

TABLE 2
WOUND CLOSURE

BEST PERFORMED BY		Catgut	Cotton	Silk	Wire
Surgical Subspecialties					
115	Gen. Surgery	81	27	20	8
69	Gen. Surg.—Gynecology	26	8	16	8
37	Gynecology	18	9	11	2
20	Orthopedics	13	3	1	1
7	Miscellaneous*	5	1	1	0
5	Urology	4	0	1	0
4	Thoracic	2	1	1	0
257	Total	149	49	51	19

* Denotes several subspecialties of surgery performed.

3—"In abdominal wound closure, I prefer" (mentioning layers)

This applied to 228 of those answering the questionnaire. It will be noticed (Table 3) that many surgeons mix absorbable and non-absorbable sutures in the same wound, using catgut on the peritoneum and a non-absorbable material on the fascia. This is contrary to the doctrine that only one type of suture should be used in closing a wound, except for the skin. Apparently these surgeons are not experiencing untoward results or they would not continue to follow this technic. All except those using through-and-through closure, approximate the peritoneum, fascia and skin. About one quarter do not suture the muscle and only 46 per cent oppose the superficial tissue.

TABLE 3
CLOSURE OF ABDOMINAL WOUND
Total 228

	Periton.	Muscle	Fascia	Sup. Tiss.	Skin	T & T
Catgut	192	146	160	83	14	0
Cotton	21	19	33	15	26	0
Silk	7	4	18	6	139	1
Wire	4	5	14	2	5	2
Clips	0	0	0	0	52	0
Dermal	0	0	0	0	13	0
S. W. Gut	0	0	0	0	8	3
Total	224	174	225	106	257	6

SUMMARY

1. It is important to know the characteristics of all suture materials and to realize that each has a use in surgery.

2. Until an ideal suture material can be found, more than one type should be used, depending on the indications.

3. For the clean operation, non-absorbable sutures offer the best results. They should not, however, be used in infected wounds.

4. The analysis of questionnaires of 298 surgeons in New Jersey reveals that there is a shift to a wider use of non-absorbable sutures, the use of smaller sutures by the greater majority, and an increasing realization that meticulous gentle surgery, with careful hemostasis and accurate apposition, gives the best results.

161 Roseville Avenue

KOPETZKY'S CONCEPT OF DEAFNESS, TINNITUS AND VERTIGO
A Critical Review *

Henry Z. Goldstein, M.D., Newark, N. J.

Dr. Kopetzky has recently written a book reviewing the anatomy, physiology and primarily medical treatment of deafness, tinnitus and vertigo. The author makes his own deductions on the various research works in physiology, pathology and biochemistry. The book is divided into ten chapters, each an essay upon some phase of the subject.

For review purposes, the text can be divided into four sections. The anatomy and physiology of the cochlea and vestibular mechanisms with functional tests are first considered. Next, the author reviews the effects of systemic and skeletal diseases on the ear followed by a study of biochemistry in 300 of the author's patients. Based on the biochemical findings, the author then attempts rationally to apply treatment.

The section on basic sciences is composed of classic standard material which, for the most part, is non-controversial plus the highly controversial MacNaughton-Jones theories of transmission of sound stimuli to the round window and his studies on equilibrium. Dr. Kopetzky seems more inpressed with these studies than other workers in the field. The author introduces his concept of an amplitude reduction mechanism due to various curvatures and decreasing diameters of the various widths of the external auditory canal. This concept merits further consideration and investigation. The functional tests of both cochlea and equilibratory apparatus are briefly described, rather too incompletely for a book of this type. The author leans heavily on Fowler's numerous contributions and studies of tinnitus.

The author then discusses the effects of systemic diseases on the ear. Syphilis, osteomyelitis, parotitis, meningitis, multiple sclerosis, syringomyelis, encephalitis, arteriosclerosis and Menières disease are mentioned. He follows the old classification of Menières Disease, Menières Symdrome, and pseudo-Menières symptom complex. Lindsay's classification is simpler and less confusing. The author does not mention Hallpike and Cairns work on endolymphatic hydrops.

The relation of skeletal diseases such as osteogenesis imperfecta, senile osteoporosis, rachitis, osteomalacia, osteitis imperfecta and gland disturbances to the mechanisms of the ear is reviewed. Hormones, vitamins, endocrines and enzymes are interrelated to the ear findings.

The author is unswervingly rigid in his criteria of what constitutes otosclerosis. He goes beyond Bezold in his standards. He also points out that all ossicular chain immobility does not mean otosclerosis. He divides those cases presenting immobility of the ossicular chain due to an actual ankylosis of the footplate of the stapes into three subgroups:

Subgroup 1: Cases in which the intralabyrinthine perilymphatic pressure is above normal.
Subgroup 2: Spasmophilic otosclerosis due to lack of accommodation between the tensor tympani and stapedius muscles.
Subgroup 3: True stapes fixation due to calcification of the annular ligaments.

This whole classification and the logic and deductions based upon these theories are still controversial. Bruehl's theory of mechanical irritation, Guggenheim's theory of avitaminosis, Gray's theory of circulatory defect, and Holmgren's theory of perilymphatic hypertension are all included in the author's deductions.

Dr. Kopetzky then reports the blood chemistry of 300 cases of undifferentiated deafness. In this table, he divides the findings into normal, more than normal, and less than normal. What is normal? How much above, and below normal? The reader is left in the dark as to the answers of those questions. According to this table, whole blood urea nitrogen, blood serum total cholesterol, and blood plasma

* Based on a review of *Deafness, Tinnitus and Vertigo.* By Samuel J. Kopetzky, M.D., Thomas Nelsons and Sons, New York (1948).

pyruvic acid (which is used as an indicator of vitamin B1 level) were mostly more elevated than in high normals. Whole blood uric acid, whole blood sugar and blood serum percentages for total proteins and for albumin were found to be lower than normal. Unfortunately a similar table giving the blood chemistry of 300 non-deafened individuals in the same age groups by the same observers is not given. There seemed to have been no "control" study made. It would have been more conclusive also, had definite figures been given rather than the vague terms of "above" and "below" normal. Slight errors in technic would compromise such undue significance given to these findings.

Based on the blood chemistry findings plus other studies of gland, hormone and psychologic studies, the author recommends treatment. If the reader feels that the tables of abnormal blood findings are inconclusive, then the therapy must also fall in the same category.

The author continues his objections to the widespread use of surgical fenestration and still insists that only one out of three deafened patients who present evidence of progressive deafness with suggestion of stapes ankylosis may get a good result with fenestration. This is because two-thirds of those having stapes fixation at the oval window present actual otosclerotic lesions at the round window also. The statistics of Shambaugh and Lempert are at variance with this statement. Walsh, Day and others report 90 per cent of their operative cases had stapes fixation. Dr. Kopetzky, however, does recommend the minor intratympanic surgery for adhesive processes which prohibit ossicular movement.

In these cases of deafness and tinnitus with or without vertigo, the author recommends the use of the following therapy depending upon careful medical studies: Jacobson's benzyl cinnamate intramuscularly, anterior pituitary, B-amino Complex, estrogens when indicated, high protein diet, salt-free diet, injections of Amvitol, Knox gelatin, bile salts, histamine desensitization and thyroid when indicated. In otosclerosis, hearing may remain at one level for years, become worse suddenly, then remain steady for years which confuses the results of medical treatment.

I have used Jacobson's solution, Hyvanol and Amvitol with control audiograms and in carefully selected patients with disappointing results. It would be unfortunate to rely on extensive prolonged medical treatment and deprive the patient of a chance of surgical relief.

Many cases are seen too far advanced for any therapy and in these, Dr. Kopetzky discusses aural rehabilitation, speech reception training, lip-reading and hearing aids.

This book, according to the preface, aimed to present the essentials for a clear conception of the factors producing tinnitus, vertigo and deafness. That aim has not been fulfilled. Dr. Kopetzky has written a provocative book but his rationally applied therapy based on more or less uncontrolled studies is not decisive. The therapy based on the biochemical studies needs further investigation and corroboration.

31 Lincoln Park

PSYCHIATRIC FELLOWSHIPS AVAILABLE

The Child Center of the Department of Psychology and Psychiatry, Catholic University, Washington, D.C., announces a fellowship ($3,200., $2,800., $2,400. for 11 months) in child psychiatry for physicians who have completed one year of internship, and one to three years of psychiatric training under supervision approved for the American Board of Psychiatry and Neurology. There will be one vacancy in February, 1950, and two vacancies in July, 1950.

Further information may be obtained from the Director of the Child Center, Catholic University, Washington, D. C.

HYDRYLLIN † FOR THE COMMON COLD

M. M. Kessler, M.D., North Arlington, N. J.

Antihistamine therapy is a new tool for use in combating the common cold. Its initial application was undertaken by the Navy during the war, but was discontinued because of the large number of debilitating reactions. To surmount the problems that the Navy faced, "trial runs" with numerous antihistaminics were undertaken in this project. A portion of eighty patients received each of the antihistaminics tested in order to find a preparation which caused fewest side reactions:

Drug	Side Reaction	Type of Reaction	Effectiveness on Colds*
Benadryl	80%	Depression	3
Pyribenzamine	65%	Depression	2
Thenylene	40%	Depression	2
Thephorin	10%	Varied	3
Hydryllin	2%	Stimulation	4

* Keyed as follows: 4 excellent; 3 good; 2 fair; 1 poor.

Because of the low incidence of side reactions and its high effectiveness, therapy with hydryllin was undertaken. Intention of this project was to ascertain:

1. Whether hydryllin was effective in the treatment of the cold.
2. During what phase it was the most effective.
3. How much time was required to alleviate symptoms.

Three phases of the cold were recognized: (a) rhinitis or invasion, (b) edema or tissue reaction, (c) secondary infection. One thousand patients returned detailed questionnaires from February 1948 to June 1949. It is on the basis of these cases that this report is made.

The routine consisted of one tablet of hydryllin every four hours for six doses. Occasionally, two consecutive courses were necessary.

Eight hundred seventy-three (or 87.3 per cent) of the patients in sample reported slight to marked improvement depending upon the phase at which they were seen; 68 per cent reported marked improvement, 23 per cent moderate improvement, and 9 per cent slight improvement.

Phase When Seen	Proportion of 873 Improved Cases	Duration of Symptoms After Treatment
Rhinitis	80%	24 to 48 hours
Edema	15%	24 to 72 hours
Secondary infection	5%	48 to 96 hours

Eighty per cent of the total cases improved came to us within the first twenty-four hours after onset of symptoms or during the phase of rhinitis. This group showed the most marked improvement following institution of therapy. Of the total number of cases in sample, one hundred twenty-seven (or 12.7 per cent) reported no improvement.

The psychologic factor is always to be considered when such a project is undertaken. To eliminate this possibility, one hundred additional patients received placebos. The tablet was identical in size and shape with the hydryllin tablet used in this project. Seven patients on placebo reported improvement and ninety-three were unimproved. Thirty who had previously received hydryllin on more than two occasions and who were improved were then given placebos and in no case was improvement reported.

About 5 per cent of the patients who had had complete alleviation of symptoms, returned twenty-four hours after therapy had been discontinued, with symptoms similar to those for which they were initially treated. This may imply either that reinfection had taken place or that the progress of the infection had been temporarily halted by antihistamine therapy, only to become reactivated after therapy had been discontinued. The second explanation seems more probable. Reinstitution of therapy in these cases caused complete alleviation of symptoms.

The 127 patients who were not improved by simple hydryllin therapy were usually found to have secondary infection or to be in the third phase of their cold. To offer these patients some type of relief the following routine was adopted: the patient was given ten

† Furnished by G. D. Searle and Company, Chicago.

minutes of diathermy treatment to the sinuses followed by tampons saturated with tuamine or ephedrine, followed by the hydryllin routine. Fifty per cent of these cases showed marked improvement within twenty-four to forty-eight hours.

It is believed that during the first stage of a cold, the tissues of the upper respiratory tract are either sensitized to the virus invading it or are locally damaged with the release of histamine. Sensitization also involves the production of histamine or a histamine-like substance. This first phase, therefore, was most beneficially affected by hydryllin since antihistaminics stop or reverse these reactions. The histamine action, if not checked, then causes increased capillary permeability, thus bringing about the second phase or edema. This is more difficult to reverse as our statistics show. Finally, tissue damage lends itself to further invasion by the virus and by secondary invaders. Thus the purulent phase of the cold results. If this chain of events is remembered, antihistamine therapy then takes on a more universal implication, namely its use in other infectious processes which basically involve this same chain of events. Experiments to evaluate this are now being undertaken.

The common cold presents a difficult problem to the physician and a serious annoyance to the layman. Industry is constantly tormented by this disease because of man-hours lost. Colds account for the largest proportion of industrial absenteeism. This project was conducted among employees of the Plastics Department of the E. I. du Pont de Nemours & Co., Inc., Arlington, N. J. A study was made of the number of man-hours lost this year, compared with the record of previous years. Man-hours lost due to colds were diminished by approximately sixty per cent, after introduction of this program.

SUMMARY

1. One thousand patients received hydryllin therapy for treatment of colds. Eight hundred seventy-three were improved and 127 were unimproved.

2. Early institution of treatment makes this therapy more effective.

3. Man-hours lost due to colds was decreased by approximately sixty per cent at the plant where the experiment was undertaken.

20 Ridge Park Drive

HYDATIDIFORM MOLE *

REPORT OF AN UNUSUAL CASE

Paul Grossbard, M.D., Passaic, N. J.

This case is reported because of the diagnostic problem due to complete absence of any of the classical signs or symptoms associated with hydatidiform mole and because of the unusual length of time it was retained *in utero*.

A twenty-six year old white female, para two, gravida two, came to me on April 15, 1947, complaining of an amenorrhea of eight months' duration and a weight gain of seventeen pounds in seven months. Last menstrual period was September 2, 1946. In November 1946, her family doctor made a diagnosis of intrauterine pregnancy. Three months later, she was told that she was not pregnant but that she had a tumor. A Friedman test was reported as negative, and later she was informed that she had an ovarian cyst.

General physical examination was negative. Blood pressure was 110/70. There was a symmetrical mass in the midline, rising out of the pelvis and extending to within one finger of the umbilicus. Pelvic examination confirmed this finding and the impression was that it was a uterus the size of a four and one-half month pregnancy. The diagnosis at this time was intrauterine pregnancy, the patient probably having conceived during this previous period of amenorrhea.

* From the Department of Obstetrics, Beth Israel Hospital, Passaic, N. J.

I again saw her on May 8, 1947. The mass was still one finger below the umbilicus. A flat plate of the abdomen revealed a symmetrical mass the size of a four and one-half month pregnancy. No fetal parts were demonstrable. A Friedman test was "weakly positive". One month later the uterus was still the same size and again the Friedman test was "weakly positive". At no time did she complain of vaginal bleeding, vomiting, or abdominal pain.

The diagnosis of "missed abortion" was made and the patient was given 25 milligrams of stilbesterol daily for one week and then half a cubic centimeter of pituitrin every half hour for four doses. Mild contractions ensued but ceased in the next twenty-four hours. One week later this procedure was repeated with no results.

I advised laparotomy, but the patient did not return to me for four months. During this time she visited other physicians but there was no change in her condition. Friedman test at the time of hospitalization was still "weakly positive". Although the tentative diagnosis was a missed abortion, in view of the peculiarity of the patient's clinical course, the possibility of an ovarian or uterine tumor had to be considered.

At operation on October 15, 1947, the uterus was found to be symmetrically enlarged to the size of four and one-half month pregnancy. A hysterotomy was performed and a hydatidiform mole removed. The ovaries were entirely normal. Postoperative course was smooth and Friedman tests at monthly intervals for over a period of a year were consistently negative.

Pathologic Report: The specimen consisted of a segment of placenta-like tissue, measuring 10x9x2½ centimeters. On one side the placental tissue was covered by grape-like formations, many of which were received separately. They varied 3 to 20 millimeters in diameter and were filled with clear fluid. No fetus could be identified in the specimen.

Microscopic: Sections showed a typical appearance of hydatidiform mole, with trophoblastic proliferations, hydropic degeneration of the villus stroma, and scantiness of the blood vessels.

The usual signs and symptoms associated with hydatidiform mole are:

1. The uterus is larger than its expected size according to menstrual history.
2. Vaginal bleeding.
3. Abdominal pain.
4. Signs of toxemia.
5. Presence of polycytic ovaries.

The uterus is occasionally smaller than its expected size and the gonadotrophic titre may even be less than in normal pregnancy.[1] However none of the classical signs or symptoms were ever present in this case. According to De Lee and Greenhill[2] all their cases terminated in abortion before the sixth month, except one which was expelled at term. This mole was retained *in utero* fourteen months, and if operative interference had not taken place, might have been retained longer. The lack of findings in this case can be explained according to Payne's classification[1] by assuming a missed abortion of the mole. However, the findings of proliferation of the trophoblastic cells and lack of degenerative change do not coincide with this diagnosis.

SUMMARY

A case of hydatidiform mole is reported because of a complete absence of any of the signs or symptoms commonly associated with hydatidiform mole and because of the abnormal duration of time a mole was retained *in utero*.

211 Lexington Avenue

DOCTORS' INCOME TAX GUIDE AVAILABLE

The physicians' income tax guide for 1950, an up-to-the-minute compilation of suggestions on preparing an income tax return is now being distributed free on request to the Medical Service Department of the Schering Corporation, Bloomfield, N. J.

STERILITY STUDY AWARD

Announcement is made of a $1000 award for an essay on the result of clinical or laboratory research pertinent to the field of sterility. Deadline for this project is April 1, 1950. For details write to Dr. Walter Williams, 20 Magnolia Terrace, Springfield 8, Mass.

1. Payne, F. L.: *Surgery, Gynecology and Obstetrics*, 73:86 (July 1941).
2. De Lee, J. B., and Greenhill, J. P.: *Principles and Practice of Obstetrics*, W. B. Saunders Company, Philadelphia (1947).

STATE ACTIVITIES

BOARD OF TRUSTEES

DECEMBER 18, 1949

The Board of Trustees met in regular session on December 18, 1949, and took the following actions:

1. The President, Chairman of Board and Chairman of Finance and Budget Committee were authorized to interview the Society's Counsel to determine his sentiment on engagement of Counsel to attend all meetings of the Board of Trustees and House of Delegates.

2. Dr. Joseph F. Londrigan was appointed Executive Secretary of Subcommittee on Legislation, effective January 1, 1950, at the same salary and under the same provisions as his predecessor.

3. A policy of professional liability coverage for the State Society was authorized, subject to the approval of the Society's counsel.

4. Colorado's "Grand Jury" Plan was referred to Judicial Council for study as to its adaptability to New Jersey; findings and recommendations to be reported to the Board prior to the 1950 Annual Meeting.

5. Counsel to be asked to familiarize himself with the provisions of the "National Lobby Act" as they apply to the Society's activities and to consider suggestion that Executive Officer be registered as a "lobbyist" under that Act.

6. Dr. Murray, Dr. Scott and Mr. Bryan were authorized to attend the February 12 meeting of the A.M.A. Coordinating Committee in Chicago.

7. A letter of Society's recognition and appreciation was ordered sent National Casualty Company for their action in extending limit of monthly benefits for sickness disability from 12 to 24 months, at no additional cost to the policy holder.

8. The chairman of the Public Health Committee was named successor to Dr. Nichols as representative of our Society on the General Council of the N. J. Health and Sanitary Association.

9. Dr. Crowe, Dr. Sharp and Dr. Allman were named a special committee to study the need for field personnel as requested by the Executive Officer.

10. The report of the A.M.A. Delegates on Washington interim session was approved.

11. It was agreed that since there is no legal objection and it definitely represents less work for the county and state treasurers, the bills for the A.M.A. 1950 dues will be sent to the individual members of the State Society from the Executive Offices; checks to be made payable to the Treasurer of the State Society. The State Treasurer will notify the component county treasurers that the bills will be handled in this manner. The State Treasurer will report monthly to the county treasurers the names of those members who pay their A.M.A. dues.

12. The report of Audit Committee approving the financial statements and auditor's reports for the year ending May 31, 1949, was accepted.

13. An additional honorarium of $1000 was authorized for Mr. Joseph Murphy for legal services rendered the Society during 1948 and 1949.

14. Recommendation approved that the Society pay no bills for legal services in the future, without authorization from the Trustees, unless they be to the authorized attorney.

15. Part V, of the cancer program in New Jersey was approved and publication in The Journal was authorized.

16. Recommendation approved that the Society take membership in the Council of Professions and send representatives to its meetings. These representatives will have power to approve the Constitution and By-Laws when complete; representatives to be named by the Chairman of the Board in consultation with the President.

17. Dr. Murray was requested to arrange as soon as possible, a meeting of the Maternal Welfare Committee, the Child Health Committee, Dr. Levy and officials of the Bureau of Maternal and Child Health of the State Department of Health in an attempt to resolve the differences concerning *Standards and Recommendations for Lying-In Institutions and Newborn Nurseries.*

18. Medical Society co-sponsorship of Regional Society Hygiene Day Conference, February 1, 1950, (under auspices of the American Social Hygiene Association) was authorized. Details of Conference will be called to the attention of appropriate committee.

19. A Christmas gratuity to the clerical staff in the Trenton office was authorized.

20. A recommendation was adopted that the Society approve the Medical-Surgical Plan's coverage for maternity benefits.

SPECIALTY SOCIETIES IN NEW JERSEY

Specialty	*Name of Society*	*President*	*Secretary*	*Membership*
Allergy	The N. J. Allergy Society	Ralph Alford Montclair	William Greifinger 31 Lincoln Park Newark 2	P
Anesthesiology	N. J. State Society of Anesthesiologists	Irving Hayman Paterson	Norman B. Kornfield 52 Livingston Ave. Arlington	P
Clinical Pathology	The N. J. Society of Clinical Pathologists	William G. Bernhard Newark	William W. Hersohn 20 S. Elberon Ave. Atlantic City	L
Dermatology	Northern N. J. Dermatological Society	Henri Abel Elizabeth	S. J. Fanburg 31 Lincoln Park Newark 2	P
Diabetes	N. J. Diabetes Association	Elwood H. Macpherson Millburn	Everett O. Bauman 91 Lincoln Park Newark 5	P
Gastro-enterology	N. J. Gastro-enterological Society	Earl J. Halligan Jersey City	Benjamin I. Macchia 358 Arlington Ave. Jersey City	P
General Practice	N. J. Academy of General Practice	Aaron H. Horland Newark	Edwin Rosner 814 Haddon Ave. Collingswood	I
Gynecology (See Obstetrics below)				
Industrial Physicians	N. J. Association of Industrial Physicians	Augustus Gibson Mendham	George A. Paul 788 Lyons Ave. Irvington	S
Neuro-psychiatry	N. J. Neuro-Psychiatric Association	Charles Englander Newark	David J. Flicker 82 Clinton Ave. Newark 5	L
Obstetrics and Gynecology	N. J. Obstetrical and Gynecological Society	George German Camden	C. Norman Witte 422 River Ave. Point Pleasant	S
Orthopedics	N. J. Orthopaedic Society	Harold W. Smith Orange	R. R. Goldenberg 588 E. 27th St. Paterson	D
Pediatrics	N. J. Section. American Academy of Pediatrics	Frederic W. Lathrope (Chairman) Plainfield	Walter L. Mitchell, Jr. 161 Roseville Ave. Newark	D
Physical Medicine	The N. J. Society of Physical Medicine	Bror S. Troedsson Orange	James C. Hanrahan 678 N. Broad St. Elizabeth	P
Proctology	N. J. Proctologic Society	A. L. Reich Newark	Urban R. Finnerty 71 Park St. Montclair	P
Psychiatry (See Neuropsychiatry above)				
Radiology	Radiological Society of N. J.	Francis P. Carrigan Newark	Benjamin Copleman 280 Hobart St. Perth Amboy	D
Rheumatism	The N. J. Rheumatism Association	Daniel E. Kavanaugh Newark	Peter J. Warter 717 W. State St. Trenton 8	P
Surgery	The Society of Surgeons of N. J.	Frank McCormack Teaneck	William H. McCalllon 722 Westminster Ave. Elizabeth	L
Tuberculosis	N. J. Chapter, American College of Chest Physicians	Homer H. Cherry Paterson	Benjamin P. Potter 100 Clifton Place Jersey City	I
	The N. J. Trudeau Society	Harold S. Hatch Morristown	John E. Runnells Bonnie Burn San. Scotch Plains	P

L—To physicians who limit their practices to the indicated specialty.
P—To physicians in good standing who are interested in the specialty.
I—By invitation only.
D—To board diplomates only.
S—To physicians whose major field of practice is in that specialty.

OBITUARIES

DR. FREDERICK A. ALLING

Dr. Frederick A. Alling, noted Essex cardiologist, died at his home in Montclair on October 20, 1949.

Dr. Alling, who was 65, was born in Newark. After his graduation from Newark Academy, he studied for a year in Dresden, Germany. He was graduated from the College of Physicians and Surgeons in New York in 1911. Dr. Alling interned at New York Hospital and during World War 1 he served 14 months in France. He was an attending physician at Newark City Hospital, Presbyterian Hospital and St. Barnabas's Hospital. He served as a consulting physician at the Eye and Ear Infirmary, Rahway Memorial Hospital and Essex Mountain Sanatorium, and was on the staff of Mountainside and Orange Memorial Hospitals. He was an F.A.C.S. and a diplomate of the American Board of Internal Medicine.

CARMINE J. CUFARI

Dr. Carmine J. Cufari died at the Jersey City Medical Center on November 15, 1949, of a heart condition.

Dr. Cufari was born in Italy in 1906 and came to the United States at the age of 5. He had lived in Union City for the past ten years. He was graduated from Marquette Medical College in 1940, and served his internship at North Hudson Hospital and Margaret Hague Hospital, Jersey City. He was a member of the North Hudson Physicians' Society and the North Hudson Hospital Association.

DR. SAMUEL B. ENGLISH

New Jersey lost one of its pioneers in tuberculosis on November 3, 1949, when Dr. Samuel B. English died following a cerebral hemorrhage.

Born in Lees Point, N. J., in 1877, he was graduated from the Jefferson Medical College in 1906 and returned to intern in his native state. The following year he went to Glen Gardner to supervise the construction of the state tuberculosis sanatorium there and was designated as superintendent when the institution opened. From the beginning of his career at Glen Gardner, he visualized his task as one of prevention as well as treatment and he was the chief force behind the establishment of tuberculosis outpatient clinics throughout the state.

Dr. English was one of the founders of the state Trudeau Society and had been president of numerous medical organizations and tuberculosis leagues. He served as medical director of the state sanatorium for forty years, a record that has seldom been equalled by any institutional executive. At the time of his death, he was one of the senior tuberculosis physicians of the entire country.

DR. SAMUEL C. HAVEN

Dr. Samuel C. Haven died at his home in Morristown on November 21, 1949, after a long illness.

Dr. Haven was born in Morristown 74 years ago. He was graduated from Columbia College of Physicians and Surgeons in 1901 and interned at Roosevelt Hospital in New York.

Dr. Haven was an attending physician at Memorial and All Souls' Hospitals and Shonghum Sanatorium. He served several years as president of the medical board at Morristown Memorial Hospital and was on the advisory boards of the Visiting Nurses' Association and the Victoria Foundation. He was on the Morris County medical advisory board in World Wars I and II, and was president of the Morris County Medical Society in 1927 and 1928.

Dr. Haven was instrumental in starting the pediatric ward and laboratory at Morristown Memorial Hospital. Always interested in pediatrics, he was also instrumental in starting baby clinics in the town and was attending physician for the Speedwell Society.

DR. RICHARD KNIGHT

Dr. Richard Van Dyke Knight of Summit, died on October 29, at Harkness Pavilion of Columbia-Presbyterian Medical Center, New York, after a brief illness, at the age of 39.

Dr. Knight received his medical degree from the College of Physicians and Surgeons, Columbia University and served his residency at Sloan Hospital of the Presbyterian Medical Center. He was formerly associated with Bellevue and Lenox Hill Hospitals in New York. Dr. Knight was an obstetrician with the Summit Medical Group for four years. He was attending obstetrician at Overlook Hospital.

DR. STANLEY NICHOLS

One of the state's most valiant fighters for child welfare was lost to us on November 14, 1949, with the death on that date of Dr. Stanley H. Nichols. In 1936 he activated our state society's child welfare committee and served as its chairman or vice-chairman for ten years. He was twice chairman of our public health committee.

Born in Meriden, Connecticut in 1890, he received his M.D. at the University of Pensylvania in 1910, and soon thereafter came to Monmouth County where he practiced for thirty-eight years. In World War I he served in the Navy Medical Corps. In 1939 he received the public health award of The Medical Society of New Jersey. He became attending or consulting pediatrician at many hospitals in the shore area. He was active in church affairs, public education, medical organization, and public welfare activities of all sorts. He served on the State Board of Child Welfare, the faculty of the New York Postgraduate Medical School and the board of the Monmouth County Organization for Social Service. In 1932 he was president of the Monmouth County Medical Society. He was a founder of, and first president of, the New Jersey Health Congress.

For editorial comment on the death of Dr. Nichols, see page 3.

VIEWS AND REVIEWS

It's a Moral Issue

The distinguished British journalist, Cecil Palmer, writing recently in the *Connecticut State Medical Journal,* asserts that we must fight to preserve private practice in medicine primarily on moral grounds.

The meat of his argument is that what is here being defended and upheld is not individualism as a body of civil rights and economic privileges adhering to the individual but rather the sense of individual responsibility and, hence, the survival of the individual as the indispensable ingredient of a democratic society.

Our Connecticut colleague points out editorially that, in speaking of major influences in thought, Freudianism and Marxism, Professor Joseph Wood Krutch of Columbia University has said that "the two great prophets of the 19th Century so often regarded as opposed to one another have in common at least a very important fact in that both, whether or not they intended anything of the sort, have often been assumed to be assuring us that no man can be charged with responsibility for what he is".

"The medical profession in our country as an influential and indispensable social group", continues our Connecticut colleague, "must face the reality of their present position. They have other responsibilities than those of the sick room. Today calls for a continuing emphasis of the recognized inherent values and ideals of American medicine. This should be done in medical schools, medical societies, and other professional groups to the end that the public will realize what these things mean to their own welfare and protection. The work of a doctor is not in man hours.

"In what was meant as derogation, the profession has been said to be made up of incurable individualists. Let us accept the appellation and prove that we are also incurable Americans. The issue before us is indeed a moral one and no one has stated it more clearly than Archibald MacLeish, in a recent issue of the *Atlantic Monthly:* 'Stated in terms of structure, the real alternatives are, at the one pole, a cellular authoritarian society in which individual human beings may live their lives through the life of society as a whole and, at the other, a world of individual men whose relation to each other in the freedom of their individuality will create a society in which each can live as himself' ".

"The Sense of the Meeting"

Anyone engaged either vocationally or avocationally in group activity must spend a considerable amount of his time in meetings—especially meetings of committees and boards where formal business is transacted. Whether it be the executive committee of the county medical society, the medical board of a hospital, the trustees of a church, or whatever—most of us have numerous affiliations in which we are trying to reach an accord and to pin down decisions for joint action.

Your correspondent is possibly one of the most be-meetinged of all men in New Jersey and he is frequently wont to wring his hands and tear his thinning hair when he considers the valuable time wasted by so many busy people in attending long, windy and inconclusive meetings.

A committee has been defined as a group that keeps minutes and wastes hours. This definition, in our humble opinion, is not wide of the mark when applied to many of the committee meetings we are expected to attend.

We heartily subscribe to the frequently offered suggestion that the rudiments of parliamentary law be a compulsory subject in every secondary school in the United States.

Recently we came across a "letter to the editor" published in the *Saturday Review of Literature* which offered some engaging comments on this general topic. The author, Richmond P. Miller, Field Secretary of Philadelphia Yearly Meeting of the Religious Society of Friends, writes in part as follows:

"What we need in business, in government, in all group activity today is more experience and practice in getting the sense of the meeting. That is the testing point in the working of the democratic process. Reaching decisions is one of the most important of all the technics in learning to live together. The most fascinating political institutions perhaps in the whole world are the Swiss Landesgemeinde cantons. There we have pure democracy in government. The New England Town Meeting is another example of group thinking and deciding on the basis of pure democratic principles. We realize too seldom that the Quaker way of life has

made as distinct a contribution in the creative conduct of business and group relationships as it has in the conduct of the meeting for business."

What does Mr. Miller mean by the "sense of the meeting"? He goes on to tell us that "in a Quaker business meeting the clerk gathers the sense of the meeting and frames it into a minute adopted then and there, which satisfies minorities as well as majority opinion".

This process, he says, is being used more and more in the conduct of everyday business, especially by corporate boards of directors. Mr. Miller quotes Morris Llewellyn Cooke, an experienced management engineer, to the effect that "the Quaker method of reaching decisions by taking what they call 'the sense of the meeting', as contrasted with voting, represents a wide departure from rugged individualism. It is a process inviting continuing development. The adoption of this practice generally in the affairs of men would make for a new world."

Perhaps the Quakers have something here. Too often, in our experience, the collective effort in group discussion seems to be to accentuate the conflict. The motive seems to be to exhort and harangue rather than to listen and consider. Honors frequently go to the advocate possessing the strongest voice rather than the supporter of the soundest case. Those who have the votes or think they have them will press the issue to a conclusion, with the result that the division within the committee is more pronounced than ever and the committee itself is frequently weakened as an instrument of collective progress through the wounds inflicted by debate.

What we need, in the opinion of Mr. Miller, "is a harmonization of free discussion and quiet thinking which will develop a group willingness to accept unanimously the balanced judgment of the majority and the best informed. The sense of the meeting then will be consensus. We must learn to accommodate divergent views into common understanding so that all can act with integrity, self-respect and sympathetic understanding whenever we meet to do business together."

Is Medicine Analogous to Education?

The public school system is often cited by advocates of socialized medicine as an example of how well government may take over, run and control the public service. The contention is made that the same thing can and should be done in supplying medical service.

Now, of course, it is possible to make out a pretty good case for the thesis that public education in America is not all that it might be. In fact, it has been seriously argued that the public schools have failed to reach even their basic purpose of turning out educated or educable citizens.

This is a topic which might readily be extended into a five foot bookshelf. We shall leave it alone. One thing is certain, however, the analogy between education and medicine is insupportable.

Dr. Frank G. Dickinson, Director of the Bureau of Medical Economic Research of the American Medical Association, pointed out recently that medical care in its entirety is so fundamentally different from the educational process that there appears to be little or no basis for comparison:

"To point out any superficial likeness is to overlook the basic function of medicine, to disregard the real role of the physician, to lose sight of the very end to be desired—better medical care for the American people," he said.

"The fundamental difference between teaching and practicing medicine arises out of the fact that the teacher is concerned with a large, fairly standardized group of persons in a class composed of children or young people of somewhat similar intellectual development who presumably enjoy normal health. Her primary purpose is to teach her students to do things for themselves. Education lends itself to group organization."

As Dr. Dickinson quite correctly observes, the physician is interested in the individual. He cannot administer the same treatment to a large group of persons but must diagnose each case separately and select the treatment suitable to each patient. "He is concerned with the differences, not the similarities in persons."

Moreover, as Dr. Dickinson observes, the physician cannot offer a standardized product. Hence, his services are not adaptable to governmental regulations, fixed rules and basic standards all of which would be inevitable in any national compulsory medical scheme. In fact, Dr. Dickinson concludes, "The physician would be rendered powerless to fulfill his primary obligation to his patient if condemned to such uniformity".

J. E. B.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

ARE PEOPLE IN NEW JERSEY INTERESTED IN SOCIAL HYGIENE?

Last year they asked the State Department of Health for 57,000 pamphlets on sex education or venereal disease control.

They borrowed films from the state museum for 500 showings to clubs and other groups of citizens.

One of the goals set up by the N. J. Congress of Parents and Teachers, (for the guidance of local P.T.A.'s in program planning) is "Social Hygiene Education for Family Life". To meet this, a local organization may: (1) have a discussion group which meets at least four times and which selects a book to add to the P.T.A. book shelf for the use of all members: (2) have a reading group which reports on the books read at one of the general meetings; (3) include a brief social hygiene item (limit to 3 minutes) at each of its meetings or devote 45 minutes at one of its meetings for an approved skit or for a movie, or other visual aid concerning the non-medical aspects of family life education.

Rutgers University is giving credit courses in "Education for Family Life" at Penns Grove, Millburn, New Brunswick, and Basking Ridge. Requests from Trenton, Red Bank, Cape May and Pitman were postponed because instructors were not available. These off-campus courses have been held for several years and more than 500 teachers have been enrolled, in addition to nurses, parents and others.

The Tri-State Council on Family Relations (Connecticut, New Jersey and New York) sponsored a meeting in Newark last spring. The program featured a demonstration of teaching units in family life education and a discussion of a program in secondary schools. Dr. Charles E. Marden of Rutgers University, represents New Jersey on the Tri-State Council.

Under the auspices of The Medical Society of New Jersey, the film "Human Growth" has been shown and discussed by a physician with more than twenty groups of parents.

MORE INTERESTED PEOPLE AND ACTION GROUPS ARE NEEDED

Pharmacists in the state have cooperated for several years in the observance of Social Hygiene Day. Through the New Jersey Pharmaceutical Association, they have been supplied with leaflets to place on the counter where they are readily available to customers of the drug store.

A survey of 213 communities in 42 states (made in 1948 by the American Social Hygiene Association) indicated that open and flagrant commercialized prostitution has returned in many communities. It was reduced to an all-time low during the war by the combined efforts of military and civilian authorities and voluntary civic agencies.

In 1948, 8336 cases of syphilis and 5069 cases of gonorrhea were reported in New Jersey. Reporting is incomplete, particularly in the case of gonorrhea. In the Navy,* where the men are under *close medical supervision,* it was found that the ratio of gonorrhea to cases of early syphilis discovered was 16:1. Of the 8336 cases of syphilis reported in New Jersey 1172 were classified as primary or secondary cases. If the same ratio applies among civilians as in the Navy, there should have been at least 16 times as many cases of gonorrhea reported as of early syphilis—18,752. However, even the 13,405 cases of syphilis and gonorrhea actually reported in New Jersey in 1948 exceeded the number of cases of any of the other communicable diseases except the common diseases of childhood (chicken pox, measles and mumps).

Thoughtful people know that venereal disease is only a symptom—a symptom of ignorance, maladjustment and low standards of sex conduct.

Social Hygiene Day is an opportunity for service groups, churches and other organizations and individuals to become better informed about social hygiene problems.

Does your community have a permanent Social Hygiene Committee to bring together all who will work for the education and protection of the young people of your town?

* Babione, Robert: American Journal of Syphilis, Gonorrhea and Venereal Disease, 33:243 (May 1949).

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, November 18, 1949, with Dr. M. Browne Holoman, presiding.

Dr. C. Everett Koop, surgeon-in-chief, Children's Hospital, Philadelphia, was the guest speaker, and his subject was "The Surgical Emergencies of Childhood". This very fine presentation, accompanied by slides, gave a comprehensive survey of the remarkable advances that have been made in recent years in this highly specialized field. Dr. Koop stressed the importance of early diagnosis of these emergencies in the new-born, and showed how near-normal childhood may be enjoyed in these previously hopeless cases. Drs. Mason and Johnson briefly related some of their own experiences in this branch of surgery in the discussion that followed.

The president announced that copies of the resolution placing this society on record opposing compulsory health insurance had been sent to designated parties, including the various legislative echelons. Several replies, varied in nature, have already been received, all of which showed a deep interest in the matter.

Dr. Guion was appointed chairman of the small committee which will function as a liaison committee between the Unemployment Compensation Commission and the attending physician in temporary disability benefit cases.

Dr. John S. McQuade was approved for courtesy membership by the Board of Censors.

Under new business, Dr. Nickman brought up the matter of the financial burden that assessments, aside from dues, might impose on members completing residencies and doing post-graduate work. After much discussion, it was suggested that the treasurer advise such members that upon written request to him, approval of a leave of absence for these members would be asked of the society.

The president voiced the opinion that the society owed a debt of gratitude to Dr. Harley, Sr., for his fine work in having had made engraved gold-leaf pocket cards to be issued in further honoring the four members of our society who have been in continuous practice for over fifty years.

The president requested the support of the members in a subscription drive for *Hygeia* being sponsored by the Woman's Auxiliary.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on December 8, 1949, at the Riverton Country Club, with Dr. E. V. Davis, president, in the chair.

We were fortunate to have as speaker Dr. John Howson, who is chairman of Committee for Pelvic Study. His topic "A Decalog for the Prevention of Pelvic Cancer" was presented in simple and understandable terms. All members present came away with renewed determination to try to bring about early pelvic cancer detection.

Dr. Peacock gave the tentative Public Health Program as arranged for 1950 in Burlington County. The following forum discussions are to be held: January 13 — Diabetes — Riverside High School; February 10 — Arthritis — Palmyra High School; March 10—Pediatrics—Medford High School; April 14—Cancer Control—Burlington High School; May 12—Hospital and Public Health—Burlington County Hospital.

Dr. Bray reported that the physicians of the county have attended various lay meetings and have spoken on socialized medicine. All were well received. He also reported that two communities have a definite schedule for full time coverage of physicians' services and both were working satisfactorily.

Dr. Davis, president, reported on the recent meeting in Trenton with Press representatives. He mentioned a few questions for our consideration which were brought up by the Press.

The nominating committee reported the following officers for the next year:

President—R. W. Betts, President-Elect—T. B. Dickson, Vice-President—A. B. Peacock, Secretary—R. T. Buckley, Treasurer—W. T. Mulford, Reporter—F. W. Metzer.

The president announced that Burlington County Medical Society was one of two in the State which had paid the 1949 Special A.M.A. assessment in full.

Geo. R. Wade, M.D., of Moorestown, was elected a member of the society.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The Dispensary Building of the *Camden County Medical Society* was the scene of the society's regular monthly meeting held on December 6, 1949, with President A. M. K. Maldeis presiding.

After the reading of the minutes of the November meeting Drs. Roslyn Skyer, Robert P. Sturr, Jr., William R. Platt, Jerome R. Dorkin and Willard Drake were introduced to the society after taking the oath of membership and signing the rollbook.

The society was fortunate in having Dr. Joseph T. Beardwood, Jr., professor of Metabolic Diseases of the University of Pennsylvania School of Medicine, as the speaker for the evening. Dr. Beardwood's discussion concerned *Diabetes*. His main

theme was diet and insulin in the management of this disease.

Dr. O. R. Kline told of the recent press conference held in Trenton whereby the press was given the opportunity to ask questions of a panel composed of doctors, health directors, nurses and legal advisors, moderated by Dr. James F. Norton. This program was well received by the press and indications were that similar conferences would be held in other parts of the state.

Dr. W. T. Read, Jr., reported concerning a letter received from Dr. Lewis Coriell, medical director of the Camden Municipal Hospital, in which he outlined comprehensive data on the functioning of the hospital, the expense incurred and a financial plan for taking care of patients from outside of the city of Camden.

Before adjoining the meeting Dr. Maldeis announced that Dr. James F. Norton, president of the State Society, would speak at our January meeting.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

Dr. Anthony Pino, president, was in charge of the regular meeting of the *Cumberland County Medical Society,* held at Richards' Farm, December 13, 1949.

An interesting and comprehensive report on a meeting of the maternal welfare committee of Mercer County held in Trenton was presented by Dr. Mary Bacon. It was particularly gratifying to learn that the maternal death rate for Cumberland County, one death in 1902 deliveries, is much better than the average for the state, which is one in 1200 deliveries.

Dr. Paul Kenneth Ayars of Pt. Norris was elected to membership and the applications of Dr. Samuel B. Pole, III, and Dr. Kurt M. Hansen for transfer were accepted.

Amendments to the society by-laws were voted upon and accepted.

The scientific session was conducted by Dr. Carl N. Ware, president-elect, who introduced the speaker, George T. Ballard, M.D., a member of the medical staffs of Hahnemann and Philadelphia General Hospitals. Dr. Ballard remarked that his subject, *Geriatrics As Applied to General Practice,* is becoming increasingly important because each year more people are surviving long enough to develop conditions peculiar to the aged. His discussion was well organized and presented a great deal of practical information regarding new drugs and new forms of therapy to combat conditions which elderly patients usualy develop.

Immediately following the meeting, dinner was served.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, November 17, 1949. This affair was a joint session with the South Jersey Section of the American Chemical Society, who acted as our hosts. An informal get-together with refreshments preceded the meeting proper.

The speaker of the evening was Irving J. Wolman, M.D., director of Laboratories, Children's Hospital, Philadelphia, Pa. Dr. Wolman's topic was "New Developments in the Chemistry of the Blood". He described the various components of blood plasma and showed their importance in diagnosis and prognosis of disease. The second portion of Dr. Wolman's paper dealt with the use of anti-folic acid compounds in the treatment of childhood leukemia. A question and answer period followed this interesting presentation.

No business was transacted by the county society.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

The second regular monthly meeting of the *Hudson County Medical Society* for the current season, was held at Murdoch Hall, Jersey City Medical Center, on November 1, 1949. Dr. Vincent P. Butler presided.

The recommendations of the public relations committee in its report to the executive committee on October 14 were approved and carried out as directed.

Reports of the committee on constitution and by-laws and the diabetes committee were accepted and approved.

Col. August H. Groeschel, MC, Active Commanding Officer of the 315th Hospital Center, Organized Reserve, First Army, solicited support of the medical profession in the building of an efficient hospital unit of the Officer Reserve Corps.

The following were elected to membership: Drs. Michael H. Berman, John J. Hosay, Alfred J. Magee, and Theodore L. Saxe of Jersey City; Solomon Resnick, and Herbert Sandick of Bayonne; Abraham J. Gitlitz of Tenafly; Arthur J. Lewis of Hoboken; John F. Suermann of Weehawken.

Upon bringing the business session to a close, Dr. Butler welcomed the pharmacists of the county who were present at this joint meeting of the county medical society and pharmaceutical association. The speakers and their subjects were: Renato C. Costarella, agent of the New York Bureau of Narcotics—"Narcotic regulations and violations in the practice of medicine and pharmacy"; Thomas D. Rowe, Ph.D., dean, College of Pharmacy, Rutgers University—"Prescription writing"; and Carlton Lebow, Ph.G.—"Practical problems in the relationships of physicians and pharmacists".

A buffet supper followed adjournment.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

Under the chairmanship of its president, Dr. John Fuhrmann, the *Hunterdon County Medical Society* held its regular meeting at the Union Hotel in Flemington on October 25, 1949. Following a short business meeting, the chairman introduced the guest of the evening, Dr. James Norton, President

of The Medical Society of New Jersey. Dr. Norton led an interesting and vigorous discussion on the potentialities of voluntary health insurance for meeting the country's medical care needs and for neutralizing the threat of any compulsory sickness insurance proposal.

On motion introduced by Dr. Barclay Fuhrmann and passed unanimously, the society instructed its secretary to draft a letter to the Medical-Surgical Plan urging the inclusion of maternity benefits and the sale of individual contracts. A copy of this letter wll be sent to the Board of Trustees of The Medical Society of New Jersey.

Dr. Joseph Ecker of Clinton, was unanimously elected to membership in the society.

MIDDLESEX COUNTY

William M. Winn, M.D., Reporter

The November 19, 1949, monthly meeting was held at Oak Hills Manor, Metuchen, with Dr. Clarke, president, presiding. After a short business session, a combined meeting with the Middlesex County Pharmaceutical Association was held.

The following were elected to Associate membership: Drs. Emanuel Katz, New Brunswick; Frank W. Pisciotta, Highland Park, and Harold V. Cano, Spotswood. Dr. X. Budnicki, Perth Amboy was elected to Regular Membership from Associate Membership, and Dr. Albert Schwartz, Perth Amboy, was admitted to Regular Membership on transfer from the Bronx County Medical Society.

Dr. Clarke, reporting for the program committee, stated that the annual dinner meeting will be held at Oak Hills Manor.

Dr. H. Dieker, chairman of the 1949 nominating committee presented slate of officers for 1950. On recommendation it was moved and passed that the report of the nominating committee be accepted, and the committee was then discharged with a vote of thanks.

Attention was called to Press Conference to be held at Trenton.

Dr. Van Mater reporting for the public relations committee urged the members to be present at a forum to be given by the Economics Honor Society of Rutgers University on December 5, 1949, when the question of Federal compulsory health insurance will be argued.

The president was directed to draw up a resolution on the death of Dr. Voorhees.

The business session was then concluded and the meeting was combined with the Pharmaceutical Association to discuss joint problems.

Dr. Clarke introduced Mr. Edward Tarloski, past state president of the Pharmaceutical Association who advocated a uniform Rx blank. Mr. John Hoagland was then introduced who lectured on the proper prescribing of narcotics and urged that the doctors give the pharmacists full cooperation in this matter. Mr. Will Powers, secretary of the State Board of Pharmacy then spoke on new legend drugs. Following questions from the floor, the meeting was adjourned and a buffet supper served.

MONMOUTH COUNTY

Lester A. Barnett, M.D., Reporter

A new concept of the scope of modern thoracic surgery featured the regular monthly meeting of the *Monmouth County Medical Society* held at the Monmouth Memorial Hospital, Long Branch, on November 16, 1949. With Dr. Samuel Edelson, president-elect, presiding, the subject of "The Pulmonary Cripple" was engagingly presented and illustrated by Dr. Charles P. Bailey, associate professor of Thoracic Surgery, Hahnemann Hospital, Philadelphia. A discussion period followed, led by Dr. Thomas O'Neill, Philadelphia, and Dr. Benjamin Potter, Newark.

A memorial to Dr. Stanley Nichols was rendered by Dr. William G. Herrman and donations in Dr. Nichols' memory were directed to his church for a children's fund. The society will prepare a parchment scroll with the members' signatures for presentation to his family in his memory.

There will be no increase in annual dues in spite of increasing administrative costs; the dues will remain at $50.00 per year. A brief discussion of the medical problems of the County Welfare Home, Freehold, followed.

On recommendation of the membership committee, the following applicants were elected: Dr. Joseph M. Tobin of Marlboro to full membership; Dr. John J. Clark of Long Branch to associate membership; and Dr. S. Edward Navarra of Rumson to courtesy membership.

The meeting adjourned with an invitation to the November meeting of the Monmouth-Ocean County Pharmaceutical Society.

MORRIS COUNTY

Theodore R. Failmezger, M.D., Reporter

The *Morris County Medical Society* held its regular meeting at the Chilcott Laboratories in Morris Plains on November 17, 1949.

Dr. Gerald Pratt, associate professor of Surgery at New York University Medical College and chief of the Vascular Clinic at St. Vincent's Hospital, was the speaker of the evening. He discussed surgery of the veins of the legs. This very interesting talk was supplemented by numerous lantern slides. Following the meeting refreshments were served in the Cafeteria.

SOMERSET COUNTY

Irving Klompus, M.D., Reporter

The regular monthly meeting of the *Somerset County Medical Society* was held November 10, 1949, at 8:45 p. m., Dr. Mason Pitman, presiding, at the Somerset Hospital Nurses' Home.

Dr. W. C. Douglass introduced the speaker of the evening, Dr. Clyde Bowers of the Morristown Memorial Hospital. His discussion of *Influenzal Meningitis* contained a wealth of clinical material on this intriguing disease, which now, thanks to modern methods is amenable to treatment.

Unanimously, Dr. J. C. Patten of Somerville was elected to the society with full rights and privileges.

The State Society Welfare Committee activities report was presented by Dr. Lewis C. Fritts.

WOMAN'S AUXILIARY

"BE STRONG——BELONG"

Mrs. Norman Nathanson, President

As we approach the New Year it is only natural, and rightfully so, that our thoughts turn to it as a starting place, a new page to be inscribed upon or a time to evaluate what we have accomplished in the past year or re-evaluate what we set out to do last year.

We are on the threshhold of potentially vital moves that may affect the medical profession to its very foundations. We have seen what concerted effort can accomplish in holding the line for what we feel is logical, sensible and right. Our job is not done; to the contrary it has just begun. The opposition is strong and this strength must be matched with strength. We of the Auxiliary have not mustered our forces to the fullest. There are those who cannot see how they fit into the picture, those who are just plain lackadaisical, and those who cannot see the forest for the trees in the way. These individuals we must reach and make realize that this effort and this Auxiliary are theirs and that the final outcome will be felt by all in the profession.

The causes and net results of the proposed legislation have been written up and aired for the past year and partial success has been ours. Don't be complacent. The opposition will be back; back stronger than ever. When one contemplates that there are over 5000 doctors in The Medical Society of New Jersey, and we have a third of their wives in the Auxiliary, then our path and our efforts for this next year are pretty clearly pointed out. If we will but renew our efforts and thought toward this end, then my sincere wishes for a prosperous and happy New Year will not be mere words, but will be a reality.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

At a meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* held on October 14, two very important resolutions were passed. One resolution re-affirmed the Auxiliary's belief in the policies of the American Medical Association and The Medical Society of New Jersey—expansion of voluntary pre-payment medical insurance plans which can most economically provide maximum high standard medical care to the American people.

Recognizing the urgent need of renovations and additions to the mental institutions of this state and following the unqualified endorsement of the bond issue of $25,000,000 for the Department of Institutions and Agencies by the Medical Society of Atlantic County, the Auxiliary resolved that the Woman's Auxiliary of Atlantic County go on record as endorsing the Hospital Bond Issue which will appear on the ballot on Election Day, November 8.

The local Auxiliary was honored by the presence of several distinguished guests: Mrs. David B. Allman, president of the Auxiliary of the American Medical Association; Mrs. Norman B. Nathanson, president of the State Auxiliary and principal speaker of the evening; Mrs. R. J. Cottone, president-elect of the State Auxiliary, and Dr. M. Browne Holoman, president of the Medical Society of Atlantic County. The meeting was presided over by Mrs. Louis Rosenberg, president of the Atlantic County Auxiliary.

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on November 18, 1949, at the Hotel Traymore, with Mrs. Louis Rosenberg presiding.

A distinguished guest of the Auxiliary was Mrs. Asher Yaguda, of Newark, who is the state co-ordinator of the 1-10-20 plan for New Jersey. Mrs. Yaguda explained the plan, and commended the work already accomplished by the local group under the leadership of Mrs. James Mason, III, who is the county co-ordinator. Mrs. Yaguda also stated that the Medical-Surgical Plan of New Jersey which is, at present, open only to groups, will soon be available to individuals.

Mrs. Robert A. Bradley, chairman of arrangements, announced that the next meeting of the Auxiliary would be in the form of an informal get-together at the home of Mrs. Clarence Whims, president-elect of the Auxiliary. All members and prospective members are cordially invited. Mrs. M. Browne Holoman will act as co-chairman for the evening.

Mrs. G. Ruffin Stamps, chairman of public relations, announced that the program for the Community Day Tea has been arranged by Mrs. Harry Subin, and that the date will be Tuesday, January 31, 1950. This tea is given annually in conjunction with the Woman's Club of Atlantic City at the Hotel Strand, and this year the speaker will be Dr. James F. Norton, president of The Medical Society of New Jersey.

A very entertaining program was enjoyed by the *Woman's Auxiliary to the Atlantic County Medical Society* on December 9, at the Hotel Traymore, when Irene Madonna Buzone presented her Buzone Starlets in a song-fest, very much in keeping with the holiday season.

The Starlets opened and closed with their theme song, "When I Wish Upon a Star". The entire group sang "Happy Holiday", "White Christmas", and "Winter Wonderland". "Vilia", sung as a solo by Patsy Murray, was well received. Terry Bedell and Maura Woulfe joined their voices in an impressive duet, "Panis Angelicus". The rendition of "Strange Music" by the daughter of one of the members of the Auxiliary, Carol Merendino, was especially pleasing to the group. The final selection was "Adeste Fidelis", beautifully sung by the entire group.

Mrs. Clarence Whims and Mrs. M. Browne Holoman were chairmen of the evening. In addition to the very fine program, they made arrangements for delicious refreshments to be served.

At the short business meeting over which the president, Mrs. Louis Rosenberg presided, new members were honored with the presentation of corsages.

Essex County

Mrs. Stuart Zeh Hawkes, Press and Publicity

Mrs. Philip Santora presided at the Annual Fall Luncheon, which was held at the Hotel Suburban in East Orange, and attended by 71 members. Mrs. Pascal Balocchi, program chairman, introduced our guest speakers, Mrs. John Cottone and Mrs. Hortense Fuld Kessler.

Mrs. Cottone, president-elect of the Woman's Auxiliary to The Medical Society of New Jersey, brought greetings from that body to us. Mrs. Kessler, the first woman member of the Public Utility Commission, gave a stimulating talk on "Woman's Place in Government".

The delightful luncheon arrangements were made by Mrs. Harrold Murray and her able committee.

The Auxiliary went on record as endorsing the Hospital Bond Issue which appeared on the November 8th Ballot. Our endorsement was published in the county newspapers.

Mrs. Asher Yaguda, one of our past-presidents, has been appointed to the Governor's Commission to study the Problem of the Chronically Ill. This is a twelve man commission.

Our Annual Supper Dance was held at the Chanticler in Millburn on November 16, 1949. The Dance, in the capable hands of the chairman, Mrs. Joseph Clarken, and her co-chairman, Mrs. Otto Matheke, Jr., was a great success, socially and financially. Mrs. Philip J. Santora, president, received with the chairmen.

Mrs. Jesse Glazier, Mrs. Don A. Epler and Mrs. Ralph Autorino were on the program committee, and Mrs. Jerome Kaufman had charge of the printing. On the reception committee were Mrs. Pascal Balocchi, Mrs. John J. Torppey, Mrs. Joseph Echikson, Mrs. Harry Comando, Mrs. Spurgeon Sparks, Mrs. Kenneth Gardner, Mrs. Robert White and Mrs. Andrew Klein. Mrs. V. J. Riggs had charge of the Patrons List, while Mrs. Albert Tucker handled the publicity.

The regular monthly meeting held on November 28 at the Academy of Medicine, featured an interesting talk by Mrs. Jerry Younglove Delaney, executive secretary of the Essex County Service for the Chronically Ill. The meeting was followed by a delightful Victorian Fashion Show staged by Mrs. Pascal Balocchi. Our members modeled the lovely old gowns perfectly. The hit of the show was Mrs. George A. Rogers' wedding gown, which she so graciously lent us. Mrs. Rogers, our first president stated that the material for her dress came from Paris and that the dress was made in London.

Hudson County

Mrs. Arthur P. Trewhella,
Chairman, Press and Publicity

An open meeting on current legislation was conducted by *The Auxiliary to the Hudson County Medical Society* on November 7, at Murdoch Hall, Jersey City. Mrs. Sydney Chayes, president, greeted the members and guests from 39 women's organizations in Hudson County.

During a short business session, the following changes in committee chairmanships were announced: Mrs. John Muccia, chairman of Safety; Mrs. Edward Murphy, chairman of History; Mrs. Arthur Trewhella, chairman of Press and Publicity. The revised constitution was accepted by unanimimous vote. Plans for the dinner-dance to be held on November 30 were presented by Mrs. William Mulvihill, chairman of Entertainment.

Under the direction of Mrs. James Murphy, chairman of Legislation, the program proceeded. James F. Norton, M.D., president of The Medical Society of New Jersey, was the guest speaker. His topic was "Compulsory Health Insurance". The audience of 200 were informed on important aspects of pending legislation. A discussion period followed Dr. Norton's talk.

Hostesses for the social hour which followed were: Mrs. Euclid Ghee and Mrs. John Bergmeyer.

Somerset County

Mrs. Harold N. Wender, Press and Publicity

The first social event of the season given by *The Woman's Auxiliary to the Somerset County Medical Society* for the Somerset County doctors and their wives was held on December 17, 1949, at the home of Mrs. Scott McKinley, the group's president. It was attended by more than forty of the local doctors and their wives and proved a huge success, a typically lovely Christmas party.

January, 1950, will bring our new program and will start with an invitation to Mrs. Norman Nathanson to attend our first meeting of the new year. Two programs prepared by the Auxiliary, "The Prevention of Rural Accidents", and the "Health of the Pre-School Child" have been offered several times in the area and have proven extremely worthwhile. We are also planning to give free subscriptions of *Hygeia* to local schools.

BOOK REVIEWS

Synopsis of Hernia. By Alfred H. Iason, M.D. Pp. 500. New York, Grune & Stratton, 1949. ($6.50)

"Comprehensive brevity" is a phrase which adequately describes the synoptic story on hernia in Iason's recent monograph. He covers all phases of the modern treatment of this complex problem from classification to complications. He thus meets a definite need for a lucid consideration of this interesting subject.

Beginning with a careful anatomic consideration of the factors involved in hernia formation, the author presents the constantly increasing knowledge and improved technics of various types of hernia. Included in the newer concepts are detailed analysis of simplified methods, radical repairs and modern approaches to direct inguinal, pantalon, bladder, and sliding hernias based on a new understanding of fascial planes, and especially of the role of transversalis fascia.

One of the most interesting chapters deals with the pathogenesis and management of strangulated hernia. This variety requiring, as it does, a thorough understanding of the entire problem of intestinal obstruction, is treated in a most useful and practical manner. The author reviews rare hernias, the internal hernias and diaphragmatic hernias, furnishing a most useful reference text to these unusual lesions.

This monograph should be part of every surgeon's intimate library.

Gerald I. Cetrulo, M.D.

The American Nurses Dictionary; with Vocabulary Guide. By Alice L. Price, B.S., R.N., Milwaukee. Pp. 656. Philadelphia, W. B. Saunders Company, 1949. ($3.75)

For many years instructors in schools of nursing have been trying to encourage students to make wider use of medical dictionaries. Generally speaking, students have used these reference works with considerable reluctance, chiefly because the dictionaries available were beyond the understanding of the beginners in this expanding field. Teachers and students alike will welcome the splendid, new dictionary written by a nurse particularly *for* nurses. The elimination of terms which are not associated with nursing and the complete absence of cross-references are welcome innovations. Definitions which are simple but precise are invaluable to the nurse no matter what level of progress she has attained. And the clear way in which proper pronunciations of each word appear assures the nurse of proper usage.

The book, bound like a text and convenient in size and shape, is used with complete ease, since the print is standard-sized rather than microscopic. The index and the arrangement of material add materially to the ease with which the book may be employed. Personnel engaged in nursing and allied fields will never want to be without this valuable book once they have had a chance to explore it. No longer need scientific research be a tedious task to the uninitiated.

Wanda M. Tinney, R.N.

Coronary Artery Disease. By Ernst P. Boas, M.D., and Norman F. Boas, M.D. Chicago, Year Book Publishers, Inc., 1949. Pp 400. ($6.00)

This is the cardiologic book of the year. Every question on incidence, etiology, pathogenesis, diagnosis and treatment of one of the important medical problems of the day is succinctly and ably answered. An 8 page chapter on the action of drugs on the coronary arteries gives the pharmacology of every tried drug. The 50-page chapter on therapy is an epic and gives an unbiased account of every accepted treatment. The monograph on coronary occlusion and infarction contains a description of the confusing medico-legal topic of heart injury by non-penetrating chest blows. This is the only instance where speculative rather than proved evidence is furnished. An entire chapter is devoted to the electrocardiogram in coronary artery disease. Precardial pain not caused by coronary disease as well as sections on the mechanism of cardiac pain, the late results of coronary artery sclerosis and coronary disease in industry make this monograph of real value both to general practitioner and cardiologist. This book belongs on your library shelf.

Edward C. Klein, Jr., M.D.

Help Yourself to Better Sight. By Margaret Darst Corbett. Pp. 218. New York, Prentice-Hall, 1949. ($2.50)

May I throw my glasses away, even though I have a high refractive error? Can I dispense with artificial aid when I reach the bifocal age? These questions may be asked more frequently as the Bates method gains ground among laymen. Aldous Huxley not long ago gave the Bates method much favorable publicity in "The Art of Seeing".

Margaret Corbett's book explains the Bates method and gives detailed eye exercise instructions. Bates, a one-time ophthalmologist, has distorted some well known facts and substituted some of his own, evolving a curious theory. Mrs. Corbett in this book cites a case of a six-months old baby, blind with cataracts, who after being "trained, one day a surge of circulation (sic) through the lens brought out a flash of vision". The infant showed her delight by "blowing bubbles". Thus, Mrs. Corbett has cured high myopia, insomnia, defective vision, and paralysis of the vocal cords.

Completely ignored is the fact that scientifically controlled studies show that the poor vision due to ordinary refractive errors cannot be improved appreciably, if at all, by exercises. In myopia some patients can be taught to interpret blurred images more carefully, while some are convinced that they see better even though there is no actual improvement. However, Mrs. Corbett's book enables us to answer questions patients may ask about the Bates method. If for no other reason it should be read. Its unorthodox and extravagant claims are presented in a simple manner. This reviewer "palmed his eyes" after reaching the last page.

Irving H. Plain, M.D.

Book Reviews continue overleaf.

Operations of General Surgery. By Thomas G. Orr, M.D. 2d ed. Pp. 890. With 1700 Step-by-step illustrations on 721 figures. Philadelphia, W. B. Saunders Co., 1949. ($13.50)

Many difficulties are encountered by an author in compiling a text on general surgery and the various surgical specialties in one volume and, in presenting it in such a way as to make it of interest to the beginner as well as to the experienced surgeon. Bearing these difficulties in mind one cannot help but admire the careful thought and planning that has gone into the present compilation, a second edition of a work first presented five years ago. It seems to the reviewer, however, that the initial chapters in such works could easily be omitted, rather than bend the knee to tradition and describe only superficial problems that are much more adequately dealt with by other source material. One could also wish that a more detailed description of the posturing of patients for various types of operative procedures could have been outlined and that in the chapter of hernia, the recent excellent work by McVey could have been included. With the exception of these minor objections, the general surgeon should find great benefit in using this text as a refresher for almost any type of operative procedure.

Eugene V. Parsonnet, M.D.

Geriatric Medicine; the Care of the Aging and the Aged. Edited by Edward J. Stieglitz, M.D. 2d ed. Pp. 773. Philadelphia, W. B. Saunders Company, 1949. ($12.00)

The special problems of the tail-end of the growth cycle demand long neglected attention. As in any other specialty, the accumulation of special observations on the normal and pathologic variations of the aged and aging points up the problems and their solutions.

Stieglitz's opening chapter gives a philosophic concept of the problems of geriatrics which echoes a broadminded viewpoint on the problems of medicine in general. The patient must be considered a psychosomatic unit, that the unit must be considered as a total of its chemical, physical, emotional and biologic reactions, and that the unit must be considered in its relation to external environment. These concepts are so often forgotten in all medicine that the reviewer feels that their development constitutes one of the important contributions of this book. Individual subjects are presented by authorities like Jean Oliver, Walter R. Miles, Ralph Isaacs, Edward L. Bortz, Hobart A. Reimann, Howard B. Sprague, Stroud, Irving S. Wright and the Hinmans. In this second edition, material not directly related to geriatrics has been deleted and some revisions have been made to include more up-to-date findings. The author emphasizes that geriatrics is not a specialty in the usually accepted sense, and hopes that it will never become so limited. This book is a contribution, not only to the science of medicine, but, perhaps more important, to the sometimes forgotten art.

Everett O. Bauman, M.D.

Gynaecological Histology. By Josephine Barnes, M.A., D.M. Pp. 242. New York, Grune & Stratton, 1949. ($6.50)

There is a Chinese proverb "One picture—same 10,000 words". With this as a yardstick, the equivalent of 14 million words has been compressed between the pages of this small volume! There are only 49 pages of text; the rest of the space is devoted to 162 photomicrographs of high quality printed on semi-gloss paper. Beneath the photomicrographs, each of which is four inches in diameter, is a short explanatory note pointing out the salient features.

The subject matter is divided into 7 chapters covering the normal and abnormal histology of the uterus, the cervix, the tube, the ovary, the vagina, the vulva and pregnancy. There are also scattered pages of text dealing with some of the more common and important lesions of the female genital tract.

This book will be most useful for the medical student or for a gynecologist reviewing pathologic histology for his Board examination. It is also a handy reference to which the general practitioner or gynecologist could turn for help in visualizing a histopathologic report.

Although one would perhaps like to see certain details stressed a little more, the author is to be commended for her generally successful presentation of material by the visual route. The photomicrographs with their brief notes will convey much more readily assimilable information to the less advanced student than would pages of precise but dull histopathologic description.

George L. Erdman, M.D.

Modern Practice in Ophthalmology. Edited by H. B. Stallard, M.D. Paul B. Hoeber, Inc., 1949. ($12.50)

This book is an excellent guide to which the general practitioner may refer when he shares with the eye specialist the responsibility of treating a case of ocular disease, and when it falls to his lot to deal with a case in some remote part where there is delay in obtaining a consultant. It would also serve as a good introduction to the study of ophthalmology, and as a textbook for medical students.

In the first five chapters, anatomy and physiology, pathology, medical ophthalmology, methods of examination, and ocular therapeutics are clearly and concisely discussed. The next nine chapters deal with the diseases of each of the major eye structures — including etiology, clinical features and treatment in a brief but complete manner. The remaining chapters are devoted to glaucoma, refractive errors, strabismus, injuries, tropical ophthalmology, and surgery.

An appendix gives the standards of vision for the British armed services, railway workers, civil service, et cetera.

The book contains 231 illustrations plus 30 pages of colored plates. Most of the latter are the familiar Hamblin paintings and include 34 fundus conditions.

Arthur E. Sherman, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **January, 1950** **No. 1**

COUGH is a common symptom, yet often it is not evaluated properly nor treated effectively. The physician is confronted with the questions: What is a cough? What are the causes of coughing? What should be done about it?

COUGH

Cough may be distressing and purposeless but more often it is a necessary and useful act. Cough can be produced voluntarily but more commonly it is a reflex response frequently reinforced by volition.

The act of coughing can be divided into three phases, namely: inspiratory, compressive, and expiratory. During the inspiratory phase there is a deep, often quick inspiration, followed by closure of the glottis. This results in an increase in intrapulmonary pressure, the compressive phase, immediately preceding expiration. During the expiratory phase the air is forced out with the production of characteristic cough sounds.

The function of cough is the removal of mucus, inflammatory exudate and other material from the air passages, or foreign bodies and other materials which may have been aspirated into the tracheobronchial tree.

Cough is a complex act which depends for its effectiveness on a number of factors. Important among these are bronchial movements which are dependent upon the ability of bronchi to elongate and increase their diameter during inspiration and to shorten and decrease their diameter during expiration. During the expiratory phase there is also forcible compression of the lung through action of the diaphragm and the chest wall.

The narrowing of the bronchus is greatly accentuated in asthmatics and in cases of pulmonary emphysema. It is observed least in persons with pulmonary fibrosis or anthracosilicosis. This compressive action forces secretions upward into the larger bronchi.

Ciliary function is important in the elimination of secretions from all portions of the airway except the terminal bronchioles. During acute infections with excessive or tenacious secretions, activity of cilia may be greatly impaired.

The establishment of a condition of tolerance may lessen or obliterate temporarily the reflex cough. This is commonly observed in patients with bronchiectasis who are able to go without coughing for hours. When cough is initiated volitionally they may evacuate several ounces of pus before again relapsing into a state of tolerance.

What are the causes of cough? In the common respiratory diseases such as pulmonary tuberculosis, pulmonary abscess or other pulmonary diseases, cough is a frequent symptom, and the cause can be demonstrated by roentgen study and physical examination. Excessive smoking and chronic alcoholism produce local congestive changes in the pharynx, larynx and tracheobronchial tree which give rise to cough. Exposure to dust and fumes exerts an unfavorable influence on the respiratory tract. An extrarespiratory cause of cough may be irritation of the external auditory canal, or nasal and pharyngeal obstruction. Cough may be associated with the taking of food or fluid, in paralysis of the larynx, or in laryngeal disease. Severe productive cough occurring when one changes position suggests either pulmonary abscess, bronchiectasis or empyema with bronchopleural fistula.

In investigating this symptom a careful history of the onset and character of the cough, the presence and appearance of sputum, the time of occurrence and associated symptoms are important.

A study of the chest and the cardiovascular system should be made. The more common causes of cough should be excluded first. One should then proceed with an examination of the ears, nose, mouth, throat, laryngopharynx, larynx and neck, which can be done by any physician who has a reasonable knowledge of the upper air and food passages. The inveterate smoker should be encouraged to discontinue smoking and the worker in dust or fumes should minimize exposure in the absence of any definite localizing evidence of disease. Unexplained radiographic shadows or localized physical signs indicate bronchoscopy if the patient is an adult male. Cough with or without slight sputum is a common early symptom of bronchogenic carcinoma.

Bronchography is indicated if there is any suspicion of increased bronchopulmonary markings suggesting bronchiectasis. With a history of allergy, appropriate tests should be made.

The patient may be contented with the effects of a cough sedative or intralaryngeal instillations. The physician, however, should be interested in determining the cause of the cough.

Cough is necessary to rid the tracheobronchial tree of excessive secretions as in pulmonary abscess or bronchiectasis and in these narcotics should be used sparingly. In carcinoma, cough commonly is purposeless and is an early manifestation of bronchial irritation. In the postoperative case the cough "reflex" should not be suppressed. There must be adequate drainage of the tracheobronchial tree to prevent bronchial obstruction with secretions and postoperative pulmonary atelectasis.

If cough is purposeless, cough sedatives may be indicated. When cough is inadequate so-called stimulating expectorants are recommended. Inhalations or carbon dioxide and oxygen increase the quantity of sputum, and have been highly recommended.

The physician must regard cough as a symptom and although relief should be afforded the patient while the cause of cough is investigated, merely suppressing cough with a narcotic often will prove harmful.

Cough, Louis H. Clerf, M.D., The Mississippi Doctor, July, 1949.

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BLOOMFIELD	H. H. North, Ph. G. Phar. D., 417 Broad St.	BLoomfield 2-0326
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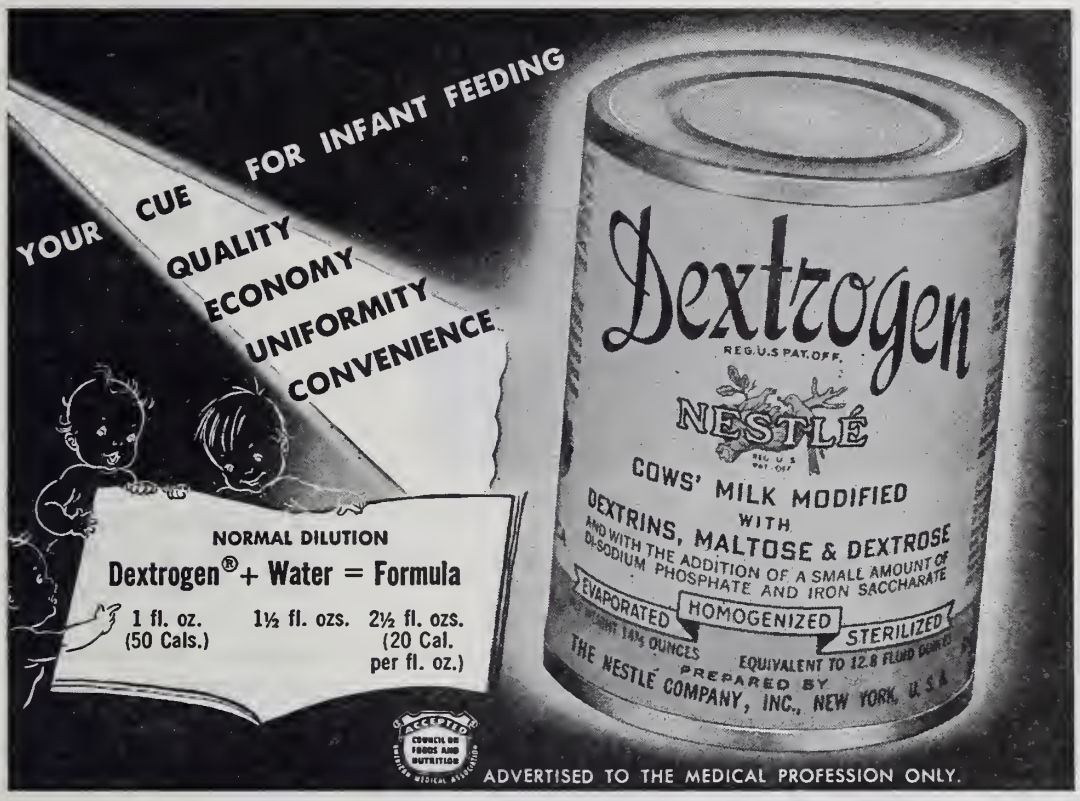

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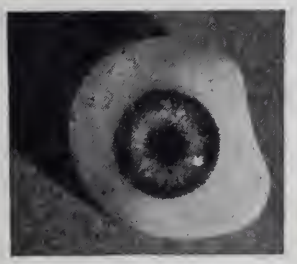

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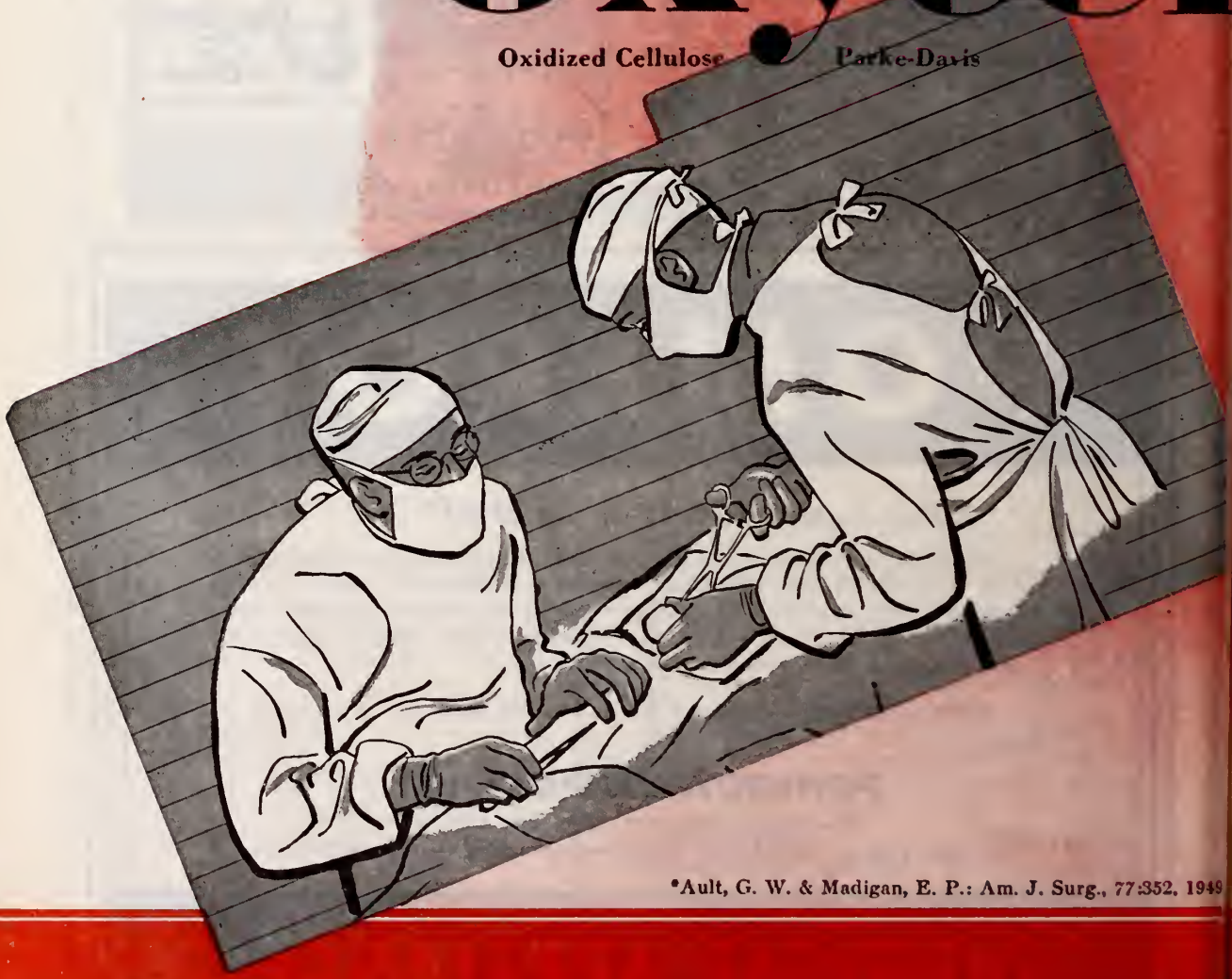

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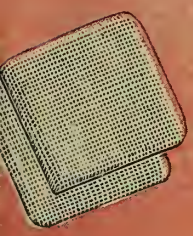

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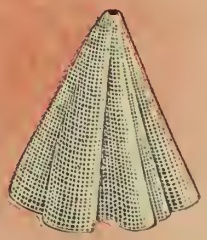

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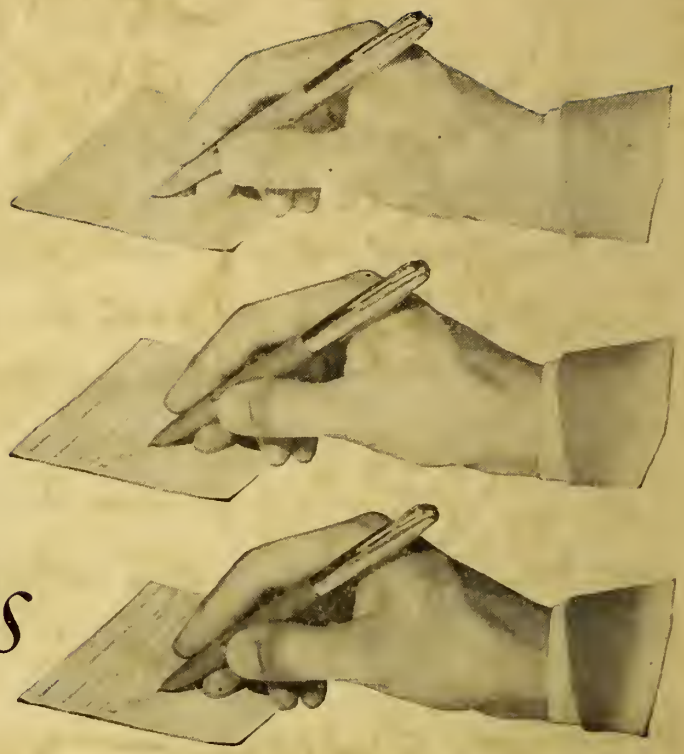

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CONTENTS—Pages 47 to 96

EDITORIALS— Page

THE INDISPENSABLE EXHIBIT 47

THEY GAVE OF THEMSELVES 48

ORIGINAL ARTICLES—

BRAIN TUMORS IN CHILDREN—Samuel A. Sandler, M.D., Hackensack, N. J. 49

THE TWO-LAYER ANASTOMOSIS—Charles Hawes Evans, M.D., East Orange, N. J. 56

TREATMENT OF MENOPAUSAL SYMPTOMS WITH ESTROMIMETRIC COMPOUND—J. J. Rommer, M.D., South Orange, N. J. 58

HEMORRHAGIC TELANGIECTASIA WITH EPISTAXIS —Otto Gambacorta, M.D., Bloomfield, N. J. 61

ARTHRITIC DERANGEMENTS OF THE HIP—Bernard M. Halbstein, M.D., Long Branch, N. J. 64

AMPHETAMINE IN THE TREATMENT OF OBESITY —S. William Kalb, M.D., Newark, N. J. 66

CRANIAL NERVE PARESES FOLLOWING RABIES VACCINATION—William Rubin, M.D., and Ned Bowman, M.D., New Brunswick, N. J. 68

THE CANCER PROGRAM IN NEW JERSEY. PART V 69

ORIGINAL ARTICLES— Page

LOWER NEPHRON NEPHROSIS FOLLOWING TRANSFUSION—Alvin H. Krakower, M.D., and Stanley Gerson, M.D., Paterson, N. J. 72

STATE ACTIVITIES—

Hudson County Graduate Program 67

Health and Medical Care Program of The Medical Society of New Jersey 74

Advance Announcement of 1950 Annual Meeting 76

Board of Trustees Meeting 81

I Remember Papa 82

Accommodations for A.M.A. Trip 83

A.M.A. Membership Dues 84

OBITUARIES 85

PUBLIC HEALTH NEWS 86

COUNTY SOCIETY REPORTS 87

WOMAN'S AUXILIARY 90

BOOK REVIEWS 93

TUBERCULOSIS ABSTRACTS 95

Roster of Officers, Advertising Page 3 A

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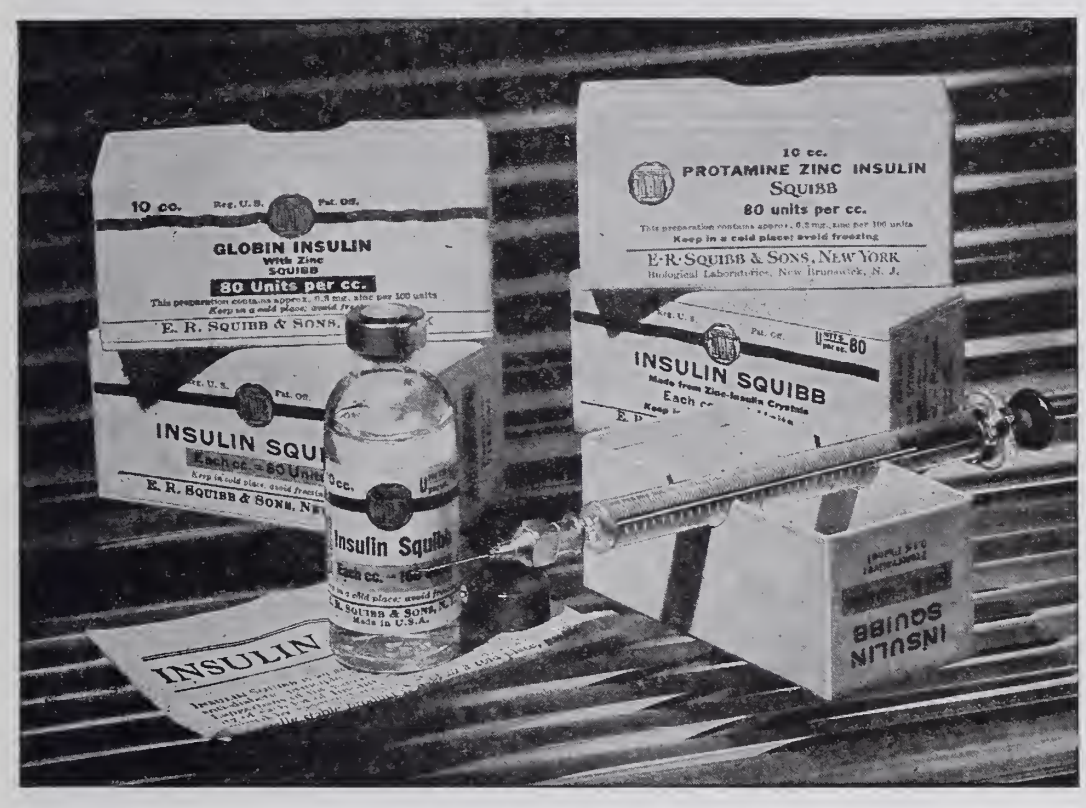

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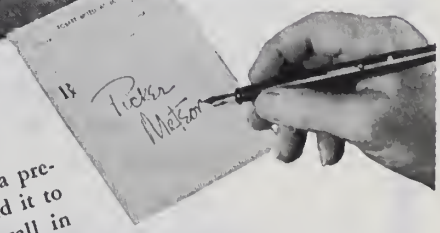

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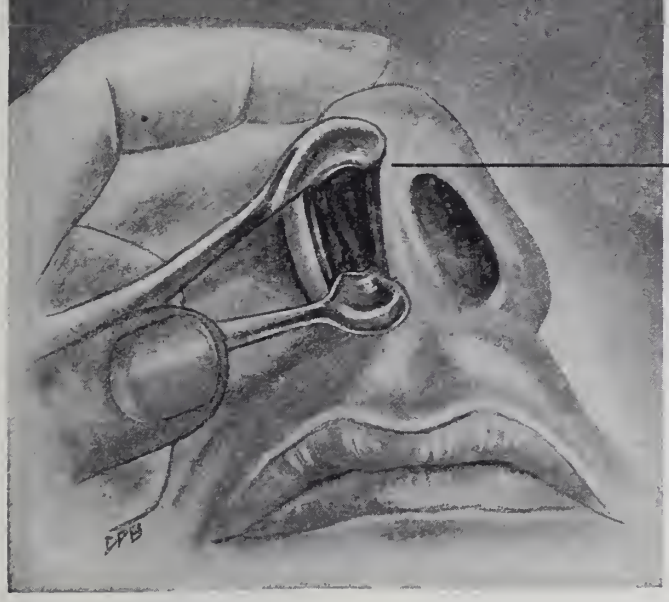

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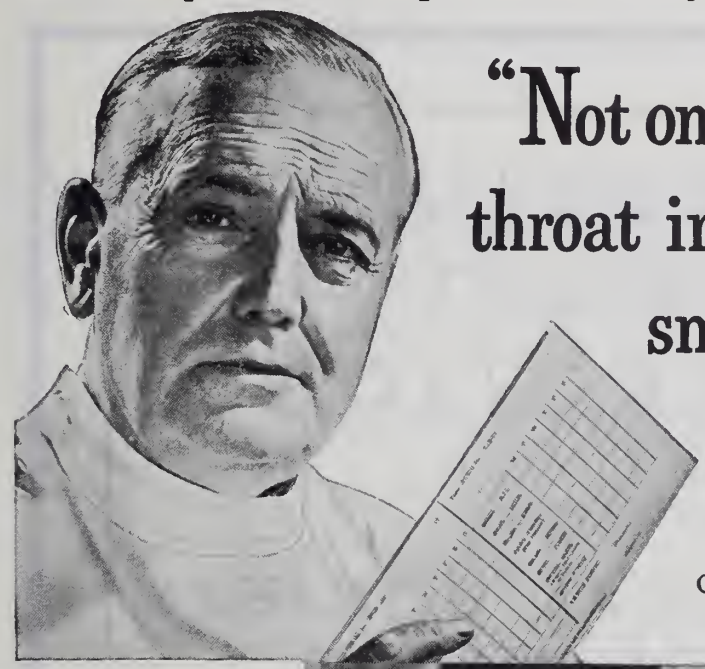

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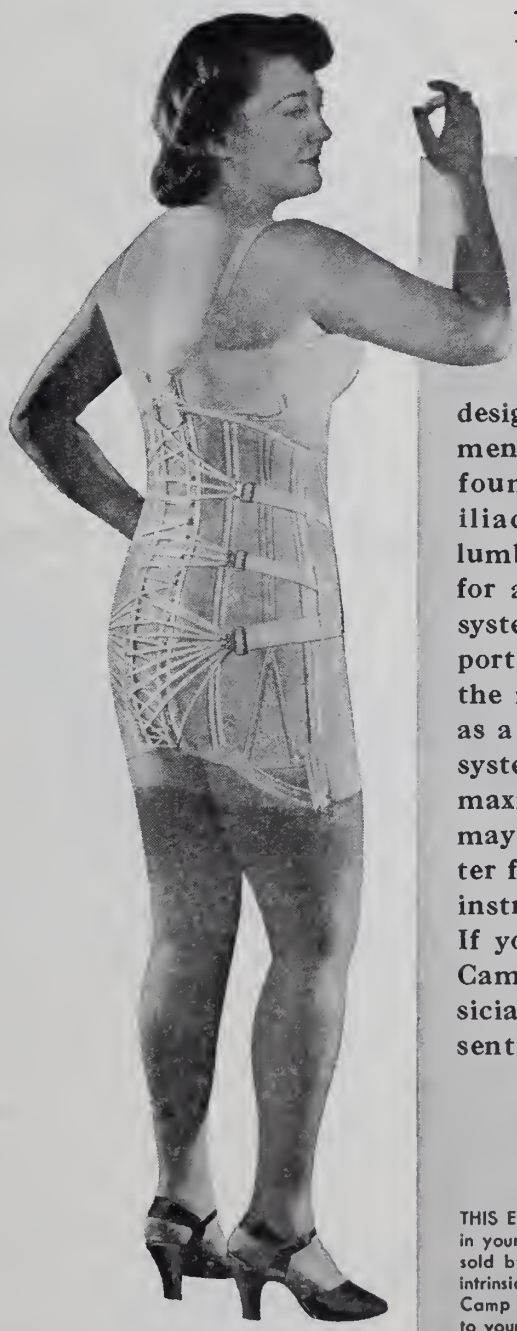

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THE INDISPENSABLE EXHIBIT

Our Annual Meeting would be but a poor shadow of its usual self, were it not for the technical or commercial exhibits. This is so for two reasons. First, because these exhibits bring you right up to the minute on the practical applications of advances in medicine and medical technology. Second—and let's face it frankly—because the rental of these exhibit booths furnishes the financial fuel that makes the entire Annual Meeting possible. If the exhibitors feel that New Jersey doctors are not interested in their displays, they will simply stop exhibiting. If they do that, our conventions will be seriously handicapped financially. Either the meetings will have to be markedly curtailed or the dues will have to be painfully raised. How do the exhibitors know whether we are interested? Only by the number of registrations at each booth. If a hundred doctors congregate around an interesting display, this makes no lasting impression on the managers in the home office—unless the exhibitor can point to a good-sized package of registration cards.

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THEY GAVE OF THEMSELVES

Elsewhere in this issue* we publish a letter sent by a young woman to her doctor-father on the occasion of the 50th anniversary of his starting to practice medicine. The letter is a heart-warming human document which we are proud to publish. Apart from the beautiful sentiment involved, it has a real significance to all of us who practice medicine. "At certain medical schools" the daughter wrote, "They train their students to divorce themselves emotionally from their patients . . . . The idea is that one can serve humanity better by a dispassionate attitude which keeps you unkinked emotionally".

Perhaps the near past always looks like a golden age. Certainly medicine was scientifically backward in the first decade of this century. At least, so it seems, by comparison with medical science today. They had to treat diphtheria without antitoxin and pneumonia without the sulfonamides and suppurative infection without penicillin. But in those days, one never heard that we ought to have state medicine, that a medical society was a trust, and that physicians were out to mulct the public. Perhaps those doctors didn't know as much about Rh and pH as we do. But apparently they knew more about people. One reason, of course, was that there were fewer specialists, more general practitioners. But it must have gone beyond that. There must have been some very special sense of responsibility that kept those doctors from refusing night calls, or threatening suit to collect their bills, or rejecting remuneration in kind, or running patients through their office on a belt line. Most people didn't have telephones, so there wasn't the opportunity to instruct the patient to drop camphorated oil in the ear—after all, that's easier today than leaving a bridge game to examine the child with an earache. Still, if they didn't feel dedicated, they could have sent the messenger back with instructions to make a mustard plaster. Only they didn't. Those turn-of-the-century doctors, pulled on their great coats and went to give the sick man the solace of their presence.

Perhaps it is unscientific to feel with the patient, to worry when he worries, to become emotionally entangled in his problems. It is much easier to perform the surgery with cool 20th century craftsmanship, to give the medication indicated by modern liver function tests, or to divide the patient's organs among a dozen specialists. We have so many magnificent accessories to scientific practice today, that maybe we don't need anything else. Our fathers didn't have many scientific aids, so they tried to make up their science by their art. By modern standards, they had so little to give by way of drugs and technic. So they gave of themselves.

* See page 82, this issue.

ORIGINAL ARTICLES

BRAIN TUMORS IN CHILDREN *

Samuel A. Sandler, M.D., Hackensack, N. J.

Although brain tumors are common, this possibility is frequently overlooked in children. One reason is that children are often difficult to examine because they may be stubborn, fearful or resistive to examination. Other children are so full of play and activity that they do not do as much complaining as the average adult, especially concerning headaches. Then again, they frequently sense the power of their own ego and defy the examiner. In children, the neurologic examination is often inadequate because of the difficulty of doing a proper sensory examination. In adults, the headache may be the first and outstanding symptom. Children, however, are often unable to explain their complaints or discomforts. In very young children with brain tumors, Gross[1] has emphasized that cranial sutures separate with the result that headaches and vomiting may not be as prominent in the early phases.

The general practitioner, who usually sees the child first, is sometimes resistive to the notion that a child may have a brain tumor. In my own experience, rarely has the possibility of a brain tumor suggested itself to the referring general practitioner. This is a point of the highest practical importance since today there is no great dearth of highly skilled, experienced brain surgeons or neurosurgical centers in the United States. Early diagnosis of a brain tumor may mean the difference between life and death. Sachs[2] states, "Brain tumors are not rare diseases. They occur so frequently that every physician may expect to encounter them and should know how to recognize them." Sachs and Hausman,[3] who have had a large experience with neurologic diseases in children, warn that, "Convulsions in children are so common that they alone need not give rise to the suspicion of tumor, but if associated with constant headaches, with vomiting and if all the symptoms are frequently repeated, the suspicion may be well grounded". The diagnosis of brain tumors in children offers more difficult diagnostic problems than it does in adults.

In the adult, the most common and persistent early sign of brain tumor is "lack of drive". In children, especially with pontine tumors, the parents may first notice that their child is becoming irritable and difficult. In cerebellar tumors, on the other hand, the examiner may note a charming, clever, and ingratiating youngster, who suddenly begins to vomit.

In addition to the medical difficulties of making an early diagnosis in brain tumors of children, there is faulty observation by the parents. In modern living there is such a multiplicity of demands on the parents that they may have too little time or opportunity to know their own children. And children themselves are living a tense, active, and exciting life to such an extent that they sometimes ignore pain or discomfort. In the metropolitan areas, children are over-stimulated or greatly fatigued from listening for hours to radio programs or excited by the television productions together with the added fatigue of their extracurricular school activities; result may be that any complaints the child has are too often dismissed by an impatient parent as the petulance of an irritable child.

Bailey, Buchanan, and Bucy[4] point out that "a child with a brain tumor may first show signs of his difficulty in his school work and conduct, such as disobedience and irritability. Later there may be a lassitude, drowsiness, and other personality difficulties." They have noted a symptom complex in childhood of persistent vomiting, headaches, staggering, and easy fatigability. They find that the cerebellum and neuraxis are more involved than the cerebral

* Read before the Section on Neuropsychiatry of The Medical Society of New Jersey, April 25, 1949.

hemisphere in children. According to their survey, there are twice as many tumors in the subtentorial region as above the tentorium. Tumors such as meningiomas, neuromas and pituitary adenomas are rare in children. Another outstanding difference between the symptoms of increased intracranial pressure in infants and adults is the enlargement of the head which results from the separation of intracranial sutures. As a result of their large experience with brain tumors in children, they state that pontine gliomas show papilledema in only about 50 per cent of their cases. Vomiting is present in about only 84 per cent, but is frequently associated with retching. It is often accompanied by abdominal pain and discomfort which results in unnecessary tonsillectomies, change of diet, and futile appendectomies. Vomiting may occur early in the morning, shortly after arising and before breakfast. Headaches in children are not picked up because children are inarticulate. Tumors of the pons may give mild, often infrequent headache. They found that diplopia and failing vision associated with strabismus is very common in the brain tumors of children.

The fact that children's sutures separate under increased intracranial pressure, may only add difficulties to the diagnosis. Thus, a child may have a tremendous cerebral neoplasm without real marked neurologic findings. Such a situation was reported by Keegan:[5] "A meningioma weighing 262 Grams within the head of an 8 year old child equals one quarter of the normal weight of the brain" of a child that age. This removed tumor "measured 10 by 8 by 5 centimeters". The tumor was removed from the left parietal region. The outstanding symptoms in this child were petit mal attacks and generalized convulsions.

Another difficulty in making the diagnosis is the normal spinal fluid pressure. I recently had the experience with a neurosurgeon who resisted operating on a brain tumor suspect because the intracranial pressure was normal. It is not generally known that many individuals with cerebral neoplasms have normal spinal fluid pressure. I have found this in a number of my own confirmed cases. Discussing this problem, Bennett and Keegan[6] rightly point out "diagnosis of cerebral neoplasm is rarely made in the absence of pressure phenomena" and they state that it is their belief that "many more patients die of unrecognized cerebral neoplastic disease than the reports in the literature would indicate". They find that "headache, vomiting and choked disks are present together in only about 60 per cent" of cerebral neoplasms. They report twelve cases of cerebral neoplasms which were verified at operation or necropsy in which there was no definite evidence of intracranial increased pressure.

Osnato,[7] pointed out that stupor is seen early and is "a prominent feature of lesions in the neighborhood of the third ventricle and midbrain generally, in children". This he thought was "due to the comparatively early obstruction of the cerebrospinal fluid circulation and consequent internal hydrocephalus". He emphasizes the differentiation between angle tumors and the intrinsic cerebellar neoplasms. In angle tumors, first symptoms are generally cranial nerve disturbances involving the fifth, sixth, seventh, and eighth cranial nerve. After these brain stem symptoms have been established for some time, they are later followed by the cerebellar signs. The prominent signs in the cerebellar lesions are the "reduced or absent reflexes, the truncal and nonequilibratory ataxia, nystagmus and intense vertigo".

One reason for delay in referring the child with a brain tumor to the neurosurgeon is that the general practitioner when he first encounters a child with vomiting, ascribes the difficulty to gastrointestinal symptoms and for weeks prescribes symptomatic treatment. If vomiting and nausea persist he may urge an appendectomy. I have seen two such cases in children with cerebellar tumors, who had had their appendices removed because of vomiting and abdominal tenderness. It has been noted by Wechsler[8] and others that abdominal pain can be the first symptom of disease of the brain. Wechsler points out that abdominal pain "is not rare. This can be inferred from the fact that in a comparatively short time I have been able to gather sixteen cases." He

adds that "abdominal pain is not generally associated with disease of the brain; when gastric distress does occur in tumors or other cerebral conditions it is either ignored or casually explained on the basis of the associated nausea and vomiting. Occasionally, if the pain is sufficiently severe, gastro-intestinal or gallbladder disease is thought of, as is also the possibility that the cerebral condition is secondary or metastatic in nature." Spiegel and his colleagues[9] have explained the mechanism of abdominal distress in cerebral lesions.

It is difficult to do an ophthalmologic examination on young children and infants. Because of their resistance and uncooperation, the visual system is neglected. Examination of visual fields in the child offers great obstacles and many children who have visual impairment and other optic tract impairment are therefore frequently overlooked. Globus,[10] finds that:

"Disturbances in acuity of vision and particularly, in the fields of vision are common in tumors of the brain and are, perhaps, more frequent than is commonly recognized. Unfortunately, there seems to be still some laxity as to the frequency and the precision with which visual fields are studied and scotomas outlined. Thus, useful information is often neglected. Indeed, in some instances, the tempo with which the papilledema develops and the degree to which it advances may often throw some light on the approximate location of the tumor. This is the case when the tumor is situated at a crucial point, particularly in areas where it is most likely to interfere with the flow and proper drainage of the ventricular fluid. In such event it is likely to cause a rapidly advancing hydrocephalus and accordingly will also provide a high degree of papilledema. Hence, with tumors of the posterior fossa, arising in the cerebellum, or in the region of the quadrigeminal plate or else somewhat more forward in the interpeduncular space in the third ventricle, papilledema will appear early, advance rapidly and reach a degree in excess of that which is usually encountered in lesions of a still more anterior location. Though it is quite patent that a tumor may interrupt the optic system at any point of its course, it is equally true that there are several crucial points at which such an interruption will give rise to fairly typical disturbances in vision. These alone, or more particularly when correlated with signs arising from involvement of contiguous parts of the brain, may take the form of a series of symptom complexes. These may be designated in accordance with the relationship of the lesion to some critical point in the course of the optic pathways as syndromes and grouped as follows: (1) Prechiasmal; (2) chiasmal, further subclassified as: (a) suprasellar and (b) intrasellar; (3) the temporal lobe syndrome; (4) the occipital lobe syndrome; and (5) the quadrigeminal plate syndrome."

PERSONALITY CHANGES

An amazing phenomenon about brain tumors in some children is that, in spite of their suffering and discomfort, their mood and temperament may remain sweet and pleasant.

Davidoff[11] states, "Over a period of 20 years in contact with neurosurgical material, it has been the author's privilege to observe several hundred child sufferers from brain tumors. The large majority of tumors of the brain occurring in childhood is located in the cerebellum. As experience has accumulated, it has appeared more and more apparent that children with tumors of the cerebellum seem to be unusually intelligent, attractive, and sweet dispositioned. One of the most striking examples of this tendency was in a small boy of 10 years who was operated by Dr. Cushing for a cerebellar medulloblastoma. This was a child of a poor Southern family which stretched every resource to the breaking point to bring the child and his mother to Boston. The tumor from which he suffered is extremely malignant and even after radical surgical extirpation, it rapidly recurred. He was returned to Boston suffering severely from headache, nausea, vomiting, and failing vision, and was eventually operated upon. The character of the child can best be illustrated by quoting a postoperative note by Dr. Cushing—'This little boy is a perfect marvel. He has waited around for a couple of weeks while I was trying to clear my slate and incidently trying to make up my mind whether I was justified to going in again. Yesterday, he told me if I didn't hurry up and operate on him he was going home because his mother was getting nervous. This morning I told him I was going to see what I could do with him without ether because another small boy with the same condition—equally marvelous—had his operation without ether, and he didn't utter a whisper during the 2½ hour performance, not even asking if I was through. Then when I was beginning to close the wound, he thanked me politely for sending word to his mother that we were nearly finished.' A letter from his mother said, 'We reached home the last of February and he passed away April 7. He suffered great pain all the time but he was cheerful and patient to the end as he was all the way through.' Nowhere in literature was a reference found to the unusual cooperativeness, intelligence and sweetness of disposition occurring in so large a number of children with tumors of the cerebellum."

Keschner, Bender, and Strauss,[12] who have made an intensive study of the mental and personality changes in brain tumor cases have the following comment: "Incidence of mental symptoms (47 per cent) in our cases of infratentorial tumor was strikingly higher than that

in the series of other observers. This, we believe, is due to the detailed psychiatric examination to which our patients were subjected as a routine. We found that many patients presented mental changes so slight that unless one searched for them with great care they could have escaped detection. Disturbances in affect were observed in 29 patients (24 per cent), 22 of whom were adults and 7 children. The changes were slight and were not persistent. Euphoria was noted in 8 patients. Several were unusually apprehensive. Eleven showed increased irritability, 3 of whom were children who cried excessively and had tantrums of temper. Of the 19 patients with tumor of the brain stem 12 were adults and 7 children. Mental symptoms were present in 7 adults and 4 children. Six patients had disturbances in affect; of these, 3 were children who were hyperirritable, lacrimose and depressed." Strauss and Keschner[13] in a previous study pointed that supratentorial tumors showed twice the incidence of mental and personality changes that were present in infratentorial lesions.

MEDULLOBLASTOMA

A common type of childhood brain tumor is a medulloblastoma. This is a highly malignant, infiltrating glioma.[14] According to Alpers,[15] medulloblastoma is found almost exclusively in the cerebellum of children. It may occur at any age, the five and six year group being the most common victims. Symptoms due to internal hydrocephalus appear early because of blocking of the fourth ventricle. Such symptoms include headache, vomiting and ocular disturbances. The cerebellar symptoms, which generally appear later, are evidenced by incoordination and difficulty in walking. The description by Cushing (cited by Alpers[15]) of a composite history of such a tumor, very vividly paints the picture:

"A pre-adolescent child previously in good health, begins to complain of headache or of suboccipital discomfort and to have occasional attacks of vomiting without preliminary nausea, usually on first arising in the morning. Attendance at school meanwhile may continue but the teacher soon notices that the child is listless or inattentive and the character of its work noticeably falls off. Ere long it is apparent that there is some unwonted clumsiness of movement and awkwardness in gait. The mother may find that the child quickly outgrows its caps and she thinks the head enlarges unduly fast. In course of time, it is noticed, at home or at school, that the child's sight is impaired; or a beginning squint of one eye may be detected, even in the absence of any complaint of double vision. The family doctor, who has previously suspected some gastrointestinal disorder, may then have the eye-grounds examined and to the surprise of everyone a choked disc is found. Three or four months has elapsed, and at about this stage of the malady many cases first come under hospital care."

Regarding the eventual outcome of operative tumors in children, Davidoff,[16] who surveyed a series of cases for 13 years following operation makes the following observations. "Of the characteristic midline cerebellar medulloblastoma occurring in children there was a total of 26 patients, who were operated on for cerebellar medulloblastoma, one survived for five years having had five operations, and the remaining 25 patients showed an average survival period of only thirteen months."

ASTROCYTOMA

Astrocytomas are common gliomas, often found in the cerebellum in children. Here, the tumors are noted chiefly in the first decade of life, most of them appearing at about the age of ten. The astrocytoma grows slowly and may be associated with symptoms extending for five or six years before relief is sought. Cystic forms are more common in children, but solid astrocytomas also are found at all ages. The cystic tumor is filled with a fluid of high specific gravity, often yellow in color, containing large amounts of protein.

Davidoff,[16] discussing his follow-up experience with astrocytoma, states:

"Forty adults with astrocytomatous tumors of the cerebrum were operated on during the three year period. Relatively few lived for over five years, average survival period being only thirty-five months; only one patient in the entire series was apparently rid of the tumor and practically well. The same gloomy prospect for these patients is indicated by the data on the entire Cushing series of 164 cases. The picture presented by histologically similar tumors located in the cerebellum, usually in children or young adults, is altogether different. Examination of the total number of cases of cerebellar astrocytoma revealed that 15 of 22 patients were alive and well at the time of the surveys, seven to thirteen years after the operation, and experience with older cases in Dr. Cushing's series indicated that the prognosis for these survivors should continue to be good. In seeking an ex-

planation for the obvious difference in the behavior of histologically similar tumors a number of factors must be taken into consideration. Undoubtedly the age of the patient and the location of the tumor are basically important constitutional factors. Another factor, however, is the greater freedom permissible to the surgeon in the radical extirpation of an infiltrating tumor of the cerebellum, the function of which can easily be sacrificed, as compared with his limitations when dealing with a tumor involving the motor or speech areas of the cerebrum."

CRANIOPHARYNGIOMAS

Craniopharyngiomas or Rathke pouch tumors, are congenital growths arising from the cell rests derived from the hypophyseal stalk and are, therefore, predominantly tumors of childhood. These cell structures are found on the surface of the hypophysis just under the diaphragm, immediately above it, or at the junction of the infundibulum and the hypothalamus. Most of hypophyseal stalk tumors compress the optic nerves and chiasm and adjacent structures. They often attain a large size, growing downward and compressing the hypophysis, spreading upward into the anterior fossa of the skull and compressing the basilar surfaces of the frontal lobes, and expanding laterally to compress the temporal lobes.

Globus,[10] in his thorough study of craniopharyngeal duct tumors, points out:

"The typical case presents a characteristic array of signs and symptoms which, in common with ophthalmologic and roentgenologic findings, make the diagnosis rather simple. The symptoms appear most often at a preadolescent age. Because of the effect of the tumor on the hypothalmic region, they include manifestations of vegetative dysfunction such as polydipsia, polyuria, sexual and skeletal infantilism, varying degrees of adiposity and hypersomnia. These, when added to bitemporal hemianopia, involvement of the oculomotor nerves and deposits of calcium in the suprasellar region without deformity of the sella tursica, point definitely to the diagnosis of a tumor of the craniopharyngeal duct in the interpeduncular space."

Discussing the surgical aspect of the craniopharyngioma, Davidoff [16] points out:

"Like the acoustic neurinoma, the craniopharyngioma, usually a partly cystic, congenital tumor, is benign, but because of its location presents almost insurmountable problems in its surgical removal. Consequently, the operative mortality is high if a radical procedure is undertaken, and frequently the patients who survive, suffer from profound disturbances of fat and water metabolism, autonomic functions and the sleep mechanism. On the other hand, simple evacuation of the cyst, while much less dangerous a procedure, usually is followed by relatively rapid recurrence of symptoms. There were 12 cases of this tumor in this series, in 2 of which the patients died immediately after operation. Of the remaining 10 patients, only 2 were still living thirteen years and ten months and thirteen years, respectively, after operation. One of these was a midget, who also suffered from diabetic insipidus. The other was a young man who reported that he was 'quite well' eleven years after operation, which was performed when he was 12 years of age and consisted of evacuation of the cyst partial removal of the solid portion of the tumor. Of the 8 patients with craniopharyngioma who died, the average period of survival was only 23 months, almost all of them were nearly or completely disabled during this period."

PONTINE TUMORS

Pontine tumors "occur chiefly in children. Symptoms of increased pressure are often absent. History usually reveals early diplopia, not infrequently with weakness, clumsiness in movement, or staggering gait. Headache is seldom a major complaint. Disturbance in gait or clumsiness in the use of the hands is noted early. Abducens paralysis is common. Absence of corneal reflex, impairment or loss of motor function of the trigeminal nerve, and facial paralysis are found. The trigeminal nerve involvement is usually of a sensory type, with decrease or loss of sensation over one side of the face. Pyramidal tract disturbances are always found, and may be evidenced by hemiplegia, hemiparesis, paraplegia, or quadriplegia. Cerebellar disturbances are always present. Choked disc is an unreliable sign in pontine tumors."

EPENDYMOMA

Ependymoma is a not infrequent brain tumor of childhood. Davidoff [16] discussing the surgical results of the ependymoma in his survey states, "Thus, of 7 patients with tumors of this type occurring in the three year period, 5 were still living, from seven to nearly fourteen years after operation, 1 died after four and one-half years, and 1 after less than two years."

DIFFERENTIAL DIAGNOSIS

The difficulty in making the differential diagnosis in cases of brain tumor, as insisted by Alpers,[15] "arises not from the occurrence of choked disc in cases of encephalitis but

from the occurrence of tumors which invade the brain stem and may therefore resemble cases of encephalitis. Such tumors, usually pontine gliomas or mesencephalic gliomas, develop most commonly in children, without fever, often without headache and with signs of progressive involvement of cranial nerves resulting in ocular palsies, facial paralysis, etc., together with cerebellar incoordination and paralysis of various types, such as paraplegia or hemiplegia. Lead poisoning, especially in children, may give rise to symptoms which resemble brain tumor very closely. Choked disc, convulsions, and focal signs referable to the cerebrum or cerebellum. In children, a lead line can be found in the long bones and the blood and urine show evidence of lead." I recently saw such a case which was thought to be a brain tumor because of papilledema and intracranial pressure of 560 millimeters of water in a 3 year old child.

"Furthermore" as Negrin points out, "certain idiopathic epilepsies both in children and adults have been found to be caused by brain neoplasms. Indeed it is not uncommon to encounter children supposedly suffering from hydrocephalus, intracranial hemorrhage, 'asymptomatic' convulsions, meningo-encephalitis, tetany, etc., actually to be having their symptoms caused by a brain tumor."

CASE REPORTS

To illustrate the problem, I am presenting, as examples, three recent cases from my private practice.

Case 1. This thirteen year old girl was admitted to the Hackensack Hospital on July 21, 1947, with the complaint that she has been unable to extend the fingers of the left hand since last October. At that time, she also noted that her left big toe would hyper-extend involuntarily causing her to lose her balance. Has also had frequent twitching of her left arm and leg, but no history of headaches or vertigo. The rest of the history was not pertinent. On admission, I found:

1. Cranial nerves all intact.
2. Weakness of the upper and lower left extremities with contractures of the fingers of the left hand.
3. The left knee jerk and the left biceps slightly more active than the right knee jerk and the right biceps.
4. The abdominals of the right more active than those of the left.
5. Left Babinski.
6. No involvement of sensation for pain or touch.
7. The 2nd cervical spine seemed unusually prominent.

A spinal tap was performed and the pressure was 120 millimeters of water. The spinal fluid was clear. My impression was a high cervical lesion of undertermined nature.

An electroencephalogram was performed by Dr. Hans Strauss of Mt. Sinai Hospital and the report was "normal". A pneumoencephalogram was done and the films were taken to the Neurologic Institute where the chief of the x-ray department stated that the pictures or x-rays were indecisive.

Due to the lack of any decisive findings or opinion, the patient was permitted to go home but it was suggested she return for follow-up. She was readmitted to the Hackensack Hospital on March 11, 1948, at which the neurologic findings were as follows:

1. Pupils were unequal—left was greater than the right.
2. Papilledema, bilaterally.
3. Impairment of ocular convergence.
4. Left mimetic facial.
5. Left hemiperesis.
6. Involvement of sensation for pain on entire left side.
7. Positive left Babinski and left Hoffman reflex.
8. Left homonymons hemanopsia.
9. Bicep reflexes greater on left than on the right.

At this time, I felt she had a tumor in the right parietal or temporal area. The x-ray report by Dr. Ryan showed, "the tables to be well formed; there is no undue bulging or exaggerated convolution depressions, the sutures show no sign of separation. The sella turcica is moderate in size; there is no erosion. The clinoids do not encroach upon the pituitary space. The pineal does not appear to be calcified."

A spinal tap was done; initial pressure was 400. After removal of 10 cubic centimeters, the final pressure was 210 of water. The fluid contained no cells. Pandy's test for globulin was negative.

The patient was operated on March 17, 1948, and a large cystic astrocytoma was found. This contained yellow fluid and a large mural nodule. The patient was in a wheel chair seven days later. Following the operation, she was given high voltage x-ray therapy to the right temporal region.

Seven months later, the neurologic examination revealed:

1. Left homonymons hemianopsia.
2. Weakness of left upper and lower extremity.
3. Left Hoffman.
4. Reflexes on left greater than the right.
5. No headaches.

It is amazing that this 14 year old girl with a massive tumor never complained of headache; the spinal fluid pressure was normal when first seen, the x-ray and electroencephalogram were negative, and the pneumoencephalogram revealed no positive findings.

Case 2. A four-year old white boy was admitted to the Hackensack Hospital, on January 22, 1948, with a complaint of fever of two days' duration. He had had two generalized convulsions. He was discharged four days later with a diagnosis of acute tonsillitis, and lymphadenitis. On June 19, 1948, he returned to the hospital. A month earlier, he had been at Bergen Pines Hospital for encephalitis following mumps. The mumps were never definitely proved. He has since shown signs of drowsiness

and a refusal to take fluids. At times he shows strabismus.

Neurologic examination revealed:

1. Bilateral optic atrophy.
2. Right facial assymetry.
3. Strabismus.
4. Impairment of finger to nose and heel to knee test on the left.
5. Suggestive Babinski on the right.

My impression was possible cerebellar neoplasm, because of the ataxia; although pituitary lesion must be kept in mind.

On June 13, 1948, a spinal tap was performed. Initial pressure was 370, the final pressure was 210. The laboratory report showed 2 white blood cells, negative Pandy, positive Mazzini, total protein 32.

X-ray of the skull was reported by Dr. Ryan as follows: "Examination of the skull shows the tables to be well formed. There are marked convolutional depressions involving all of the bones; the suture lines appear to be slightly separated. There is a marked ballooning of the sella turcica with thinning of the posterior clinoids almost to the point of fracture. Within the area of the sella, we note some irregular calcification which might be in a wall of a tumor mass or cyst."

On June 23, 1948, the patient was operated on, and a suprasellar cyst was found. The cyst was evacuated and a portion of the capsule removed. Following the operation, the child was given deep x-ray treatments.

This child exemplifies the interesting personality changes pointed out by Davidoff and myself. In spite of the great amount of pathology and discomfort, the child was pleasant, ingratiating, and even gay. His intelligence was striking. It is also interesting to note that the only outstanding marked complaint was the convulsive seizures.

Case 3. This 21 month old boy was first seen November 18, 1942. The mother stated he had difficulty in balancing himself in both walking and sitting for the past month; when he sits up he seems to "hunch" himself. His pleasant, friendly disposition was changing to an irritable, cranky one. When he tries to pick things up, he shows awkwardness and has some difficulty in raising his arms. At times he keeps his head fixed and turned down as if he were having vertigo and at other times when he sits up he slouches and seems unable to hold himself straight. Neurologic findings were:

1. Suggestive early left papilledema.
2. The deep reflexes on the right are more active than those on the left.
3. Pupils are equal and react promptly to light.
4. No nystagmus.
5. Abdominal reflexes on the right seemed more active than those on the left.
6. When sitting, there is a mild truncal ataxia.
7. Motor power seems intact.

X-ray of the skull disclosed: Vault slightly enlarged. Considerable separation of lambdoid sutures. The sagittal suture is also separated. The sella turcica does not appear unusual in size or shape. No abnormal calcification.

The history and findings pointed to a possible midline cerebellar tumor.

In January, 1943, a suboccipital exploration was done and a cystic astrocytoma of the vermis was found. Much of it was removed. He was discharged greatly improved and given a series of x-ray treatments.

The child was re-checked five years later. At this time he was attending school and doing well, but the mother stated that he has occasional headaches and a lack of appetite. The headaches were associated with vomiting. The neurologic examination, however, was negative.

CONCLUSIONS

(1) Most general practitioners are not alert to the possibility that children may have brain tumors.

(2) First symptom of brain tumors may be persistent vomiting associated with some impairment of ocular convergence and other cranial signs, motor weakness or ataxia in the absence of fever.

(3) One of the early signs of pontine tumor may be a change in personality, evidenced by increased irritability and temper tantrums.

(4) About 70 per cent of all brain tumors in children originate in the cerebellum. Many of these youngsters have a surprisingly high intelligence, are pleasant, ingratiating, and cooperative out of all proportions to the involved pathology present.

(5) Brain tumors in children may be present in spite of normal spinal fluid pressure, negative x-rays, negative electroencephalogram, and normal pneumoencephalographic findings.

(6) There is a need for greater awareness regarding the possibility of brain tumor in children because early diagnosis will often determine whether the patient will survive neurosurgery.

(7) Convulsive attacks in children (when associated with vomiting or definite neurologic findings) make it imperative to consider the possibility of a cerebral neoplasm.

NOTE: The bibliographic citations appear in the author's reprints.

254 Union Street

28117

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THE TWO-LAYER LATERAL ANASTOMOSIS *

A SAFE, SIMPLE AND EFFICIENT TECHNIC

Charles Hawes Evans, M.D., East Orange, N. J.

Leakage at the suture line, rather than contamination of the peritoneal cavity at the time of operation, is usually the cause of infection of the peritoneal cavity following anastomosis of the intestine in a well-prepared and closely observed patient. Normal healing, with little or no traumatic edema, and a satisfactory anastomotic opening should be expected following operation where the bowel is relaxed, healthy tissue is used in constructing the stoma, and there is careful hemostasis and approximation with a minimum amount of traumatized or strangulated tissue. The antibacterial phagocytic action of the peritoneum will usually take care of any mild contamination.

The technic to be described is not new. While an intern I was taught this method of anastomosing the intestines. I have used it in about 125 cases and do not remember a single instance of serious hemorrhage or leakage of intestinal content at the anastomotic suture line. The facility with which the suture lines can be placed safely when using a straight needle guided with the fingers, the accurate approximation of the cut edges of the bowel wall, the avoidance of devitalizing tissue by eliminating the hemostat and other intestinal clamps, and the surety of accurate hemostasis all warrant a detailed description of the technic of this simple anastomotic procedure.

In performing the two-layer lateral anastomosis, a continuous No. 00 medium chromic catgut suture on double straight atraumatic needles is used. The inner tier penetrates the lumen of the bowel, while the outer tier, which reinforces and protects the inner tier of suture, does not enter the lumen. The first suture placed is a simple continuous running suture; it is passed through the seromuscular coats and part of the tough submucous coat of each bowel wall then pulled taut to give a watertight approximation of the opposed serous surfaces. This suture is tied at each end with a long length of loose suture material left intact after each tie. After the outer posterior layer has been completed, the axial openings are made in each intestinal wall and the second or inner posterior suture layer is placed. This suture, which approximates the contiguous posterior lips of the intestinal openings, is a continuous overhand or through-all-coats suture. This layer is done with a new suture which is also tied at both ends and with a long piece of suture remaining after the suture line is completed and the second tie placed.

The inner or first anterior suture layer is now made, using the remainder of the suture material just tied (after completing the suture layers of the posterior part of the anastomosis). This suture, approximating the free lips of the anterior boundary of the intestinal openings, is a continuation of the continuous through-all-coats suture used to suture the contiguous cut edges or lips of bowel which form the posterior margin of the anastomotic stoma. Two or three through-and-through circles or rings of stitches are placed at the beginning and finish of this suture line to insure an accurately approximated and water-tight closure of each angle of the anastomosis. This line having been completed, the suture is tied individually or to the loose free end of the suture used to construct the outer posterior suture layer. If the everting mucosa is pushed back (as in a furrier's stitch) when the inner anterior suture line is carried forward, there will be a more accurate approximation of the layers of the bowel wall. As the outer or second anterior layer is placed, there will be still more turning in of the approximated edges; this tends to make this suture layer approach a serosa-to-serosa closure. The outer or second anterior suture layer—the last to be place—is a continuation of the outer or first posterior continuous seromuscular suture layer which was the first layer to be made. The remainder

* From the Department of Surgery, Orange Memorial Hospital, Orange, N. J.

of the suture material used for the first posterior layer is used to form this last layer which, when finished, is tied to the loose free end of suture material left when the first stitch of the first suture line was tied.

In constructing the anastomosis, the two pieces of bowel are first approximated and held together with Allis clamps, their final relationship being such that the first or outer posterior layer of suture will run along the less vascular midantimesenteric part, while the axial incisions will be nearer the least vascular antimesenteric aspects of the two loops of bowel. The axial opening in each bowel is from 4 to 6 centimeters in length and 3 to 4 millimeters from the seromuscular line of suture.

Incisions in the intestinal walls are started with a sharp knife, then extended both ways with scissors. Allis clamps are used to approximate the contiguous cut edges of bowel at each end of the incision, which form the two ends of the entero-anastomotic openings; they are then placed along the contiguous posterior lips and the free lips forming the anterior boundary of the opening. Allis clamps also are used to pick up bleeding points along the cut surfaces. These clamps (which can be placed quickly with minimal destruction of tissue and removed as a suture line is advanced) allow an accurate approximation of the angles and side walls which are to be sutured together. They control bleeding points until these are closed off with the running suture and at the same time are a great help in stabilizing the field of operation. They also will eliminate the need for guide-sutures which will occasionally tear out or leave puncture holes exposed. When the Allis clamp is used to control the bleeding points, there will be no crushed or strangulated tissue left along the lines of suture as is the case when the bleeding points are clamped, then ligated.

The outer posterior and anterior seromuscular suture lines—the first and last to be placed—must be at least one-fifth longer than the length of the incisions in the bowel. This insures that the inner suture lines, approximating the cut edges of the intestinal wall, will be surrounded completely by the outer serosa-to-serosa closure. When layers of visceral peritoneum are approximated accurately and sutured together, they are sealed with fibrin in just a few hours. This early sealing of the serosal surfaces protects the inner suture lines while organic healing or union is sealing firmly the approximated, cut, and somewhat traumatized edges of the intestine which forms the inner margin of the anastomotic stoma. By preventing early leakage of gas or fluid through the outer suture lines, the possibility of general peritonitis or troublesome adhesions in the region of the anastomosis will be eliminated or reduced to a minimum.

I do not use the Connell suture which inverts the cut edges to approximate the serosal surfaces when the lips of the anterior boundary of the intestinal openings are sutured. This serosa-to-serosa closure is not essential in the two-layer lateral anastomosis; the outer suture lines will adequately approximate these surfaces. The continuous overhand, through-all-coats suture—the same as that used for the inner or second posterior layer—has several advantages over the Connell suture when used here. The technic is simple and requires less time; the cut edges can be approximated more accurately, bleeding points not controlled with the continuous suture will be left in view instead of concealed, a firmer bowel union is formed, and there will be less encroachment on the caliber of the bowel. Here, as when the inner layer is sutured, backstitches can be taken, or the entire suture line may be reinforced when needed to pick up a bleeding point which was missed, or a more accurate approximation and seal of the cut edges of the bowel forming the inner border of the anastomotic stoma is needed.

Absorbable material gives a safe suture line and may eliminate those dangers inherent when silk or other non-absorable suture is used. A concealed catgut suture is completely absorbed during the process of normal wound healing; that part exposed within the lumen of the intestine is destroyed more rapidly. This suture increases in length when thoroughly wet and can be stretched to some extent, and when properly used will assure an airtight and water-

tight suture line while the approximated serosal surfaces are being glued securely together.

When embedded in healthy tissue, silk and other non-absorbable sutures will remain as permanent non-irritating foreign bodies. Under certain conditions they can act as irritants. When silk is used to construct the inner layers of continuous suture in the two-layer intestinal anastomosis, the suture which penetrates all the coats to become exposed within the lumen may retard normal healing; it may cause ulceration or it eventually may slough out completely. If an outer layer suture of absorbable material becomes exposed in the peritoneal cavity, it will be digested quickly. If non-absorbable, it becomes a tissue irritant which could weaken the suture line or initiate excessive adhesion formations which could retard or even eliminate normal anastomotic function. Lateral expansion of the bowel at the suture lines, due first to the dilatation and intraluminal pressure above a recently constructed anastomosis and later to normal growth, is more limited when a continuous non-absorbable suture is used to construct one or both layers of the anastomosis. Furthermore, when the outer ring of closed suture is a permanent part of the anastomosis, it may tear out when pressure in the proximal bowel attempts to widen a poorly functioning or abnormally small anastomotic opening.

SUMMARY

The technic of a safe, simple, and efficient two-layer lateral anastomosis is given in detail. The value of the Allis clamp in approximating the contiguous lips of the intestinal openings, in controlling hemorrage, and in stabilizing the field of operation is discussed. The superiority of absorable suture material over silk or other non-absorbable material, and the advantages of the continuous overhand through-all-coats suture for constructing the anterior inner tier of the anastomosis are explained.

The outer suture layer—the first and last line of sutures placed—is the fundamental layer of the anastomosis. When the serosal surfaces are accurately approximated and sutured, the union will be sealed firmly with fibrin in just a few hours. Unless disturbed, this early sealing will insure an airtight and water-tight anastomosis. The approximated, cut, and traumatized edges of the bowel forming the inner border of the anastomotic stoma are not sealed with fibrin as quickly or as securely as are the approximated serosal surfaces. Organic union of the inner suture layer—the second and third line of sutures placed—takes a relatively longer time; this is due to the presence of the cut and somewhat traumatized tissue and the inability to approximate accurately the layers of the bowel wall.

144 Harrison Street

TREATMENT OF MENOPAUSAL SYMPTOMS WITH A NEW SYNTHETIC ESTROMIMETRIC COMPOUND

J. J. Rommer, M.D., South Orange, N. J.

The symptoms of menopause are created by the complete or partial reduction of ovarian function which in turn produces an imbalance of the endocrine structure. At one time menopause was thought to be caused by high gonadotrophic values produced by the pituitary.[4] However, no correlation[1] was found between the titers and the severity or relief of symptoms.[2] Rather the titer rose with administration of estrogen, forcing the conclusion that only estrogen withdrawal produced the symptom phase.

Until eventual endocrine adjustment occurs, the administration of estrogenic substances is the best way of alleviating symptoms. Stilbesterol was found the most effective estrogen creating both an immediate and delayed response. However its toxic side reactions have

lessened its use. The introduction of a methyl radical into diethylstilbesterol not only seems to remove the side reactions but, clinically, has demonstrated effects that are prolonged far beyond those of other synthetic estrogens.[7] A large dosage [12] is necessary (since only one rat unit of activity is present in 500). When administered to domestic fowl [8] this drug was found the most potent of seventeen estrogens.

The characteristic therapeutic effect of the drug seems to be caused by the slow release of the methyl radical, *in vivo,* liberating free active diethylstilbesterol, in the following manner.[3] See figure 1.

The compound which was employed in a series of 47 menopausal and 3 surgical menopausal patients over a two year period consisted of 7.5 milligrams of dimethyl ether of diethylstilbesterol dissolved in a cubic centimeter of peanut oil, to which has been added 0.5 milligrams of diethylstilbesterol as a synergist.*

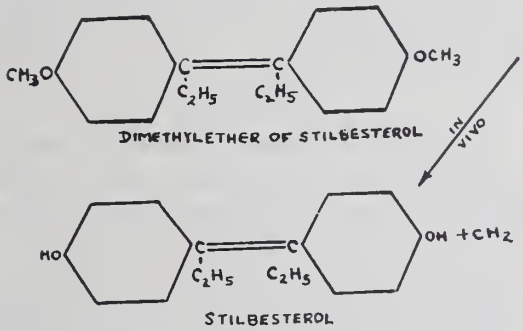

Figure 1. Demonstrating breakdown of drug in body.

The drug effects were checked by cornification of the vaginal epithelium (as evidenced by vaginal smears) as well as macroscopic manifestations of its action on the genitalia. The most noteworthy results recorded, however, were in the relief of the psychogenic symptoms with the production of a feeling of "well being". See figure 2.

In the surgical menopause cases, the effect of "ovarian function" produced was obviously that of the injected substance. Cystic glandular hyperplasia [5] often encountered with other estrogens [6] was not found in any of the cases in this series.

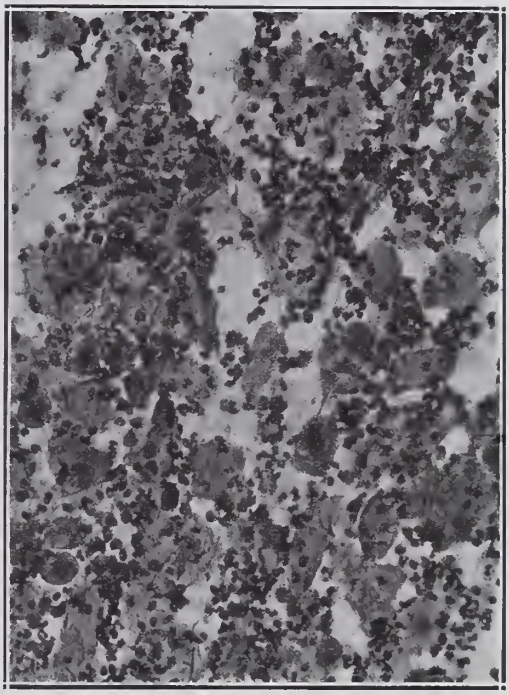

Figure 2. Vaginal smear before treatment.

Figure 3. Vaginal smear after treatment.

* Kindly furnished to the author under the trade name of synthogen, by the National Drug Company, Philadelphia 44, Pennsylvania.

Of the 47 patients treated 13 symptoms were presented, with relief indicated in table 1. The dosage and effects are summarized below:

TABLE I.

Symptoms	*No. Patients Complaining*	*Complete Relief*	*Partial Relief*	*No Relief*
Headache	12	12	0	0
Vulvar itch	4	3	1	0
Vertigo	26	21	4	1
Fear of walking	3	2	1	0
Nervousness	39	32	4	3
Hot flashes	42	37	5	0
Cold feeling	11	8	3	0
Obesity	8	4	3	1
Tachycardia	14	11	3	0
Sweating	33	30	2	1
Malaise	19	17	2	0
Depression	17	15	1	1
Insomnia	16	14	2	0
Totals	258	206	31	7†
Percentages	100%	78.3%	11.8%	9.9%

To produce the desired psychic changes, dosages of 0.5 to 1 cubic centimeter were required. Vaginal changes were effected by a dosage of 1 to 1½ cubic centimeters. Cervical changes were appraised by an increase in cervical diameter and (in some cases) by edema and/or an outpouring of mucus. This required dosages of from 2 to 4 cubic centimeters. Thirty-one patients showed abnormal vaginal cytology before injections. Five had decreased glycogen content and nine showed normal vaginal cytology before treatment. All these findings apply to the "natural menopause" group. The three patients with surgical menopause required each 1 cubic centimeter for changes in psyche, 1½ to 2 cubic centimeters for the vaginal change and 2 to 3 cubic centimeters twice a week for the cervical changes.

To test the symptom-free days under a rough standard method, the drug was administered in dosages of one cubic centimeter once weekly for four weeks, and repeated only with the recurrence of symptoms. Relief of symptoms were noted for 10 to 71 days as follows:

3 patients or 6.36% were symptom free for 60 to 71 days.

32 patients or 67.84% were symptom free for 40 to 53 days.

6 patients or 12.72% were symptom free for 21 to 37 days.

2 patients or 4.24% were symptom free for 10 to 20 days.

Four patients (or 8.48 per cent) required 2 cubic centimeter injections and were symptom free for 20 to 53 days.

The three surgical menopausal patients were relieved of symptoms for 35 to 47 days after receiving injections twice weekly for three weeks.

There was alteration of the cycle in 6 cases, or 12½ per cent. In these cases, patients who normally had a 28 to 30 day cycle menstruated in 35 to 42 days.

While no toxic effects were noted, Bloom[11] having given as much as 120 milligrams at a dose, there were two cases of withdrawal bleeding, two of slight nausea lasting one day, two of frontal headache and two of itching at the site of injection. The nausea was overcome and tolerance to the drug established after the third injection.

SUMMARY

1. A new substance, a dimethyl ether of diethylstilbesterol,* is presented as an estromimetric compound that has not only an immediate but a delayed reaction as well.

2. The drug was successful in the relief of menopausal symptoms in a series of 47 patients, yielding good results in 78 per cent as compared with stilbesterol which showed good effect in 55 per cent.

3. Six patients had side reactions, consisting of slight nausea, frontal headaches and itching at the injection site. These were mild and drug tolerance was established after the third injection.

4. There were no toxic reactions noted, even with large dosages.

The bibliographic citations appear in the author's reprints.

† Representing four patients.

* Kindly furnished to the author by the National Drug Company, Philadelphia 44, Pennsylvania, under the trade name of synthogen.

HEREDITARY HEMORRHAGIC TELANGIECTASIA WITH SEVERE EPISTAXIS *

REPORT OF THREE CASES

Otto Gambacorta, M.D., Bloomfield, N. J.

Hereditary hemorrhagic telangiectasia was first recognized as a distinct clinical entity by Osler in 1901. The symptom complex was first reported by Rendu in 1896 when he described a case of repeated attacks of epistaxis associated with telangiectatic areas of the skin and mucous membranes. Since then, many names have been attached to this disease such as: Osler's Rendu-Osler's and Rendu-Weber-Osler's Disease. In 1909, Hanes suggested that this affection be called "hereditary hemorrhagic telangiectasia" with the following definition:

"An hereditary affection manifesting itself in localized dilatations of capillaries and venules forming distant groups of telangiectases which occur especially upon the skin of the face, nasal and buccal mucous membranes and give rise to profuse hemorrhage either spontaneously or as a result of trauma."

Four cardinal findings are needed to establish a diagnosis of hereditary hemorrhagic telangiectasia. They are: (1) Hereditary tendency toward the disease. (2) Telangiectatic areas typically distributed. (3) Tendency of these telangiectatic areas to bleed. (4) A normal blood picture except for a concomitant secondary anemia in chronic bleeding.

An excellent review of the literature including discussion of etiology, diagnosis, and treatment has been presented by Peluse.[1] His discussion of treatment bears repetition since it is so pertinent to the three cases I am about to present.

TREATMENT

This is a disease of the blood vessels and not of the blood. Most logical approach, therefore, is directed toward checking the bleeding local point when it is accessible, plus the use of any medicinal agent that might have influence on the strength and integrity of the capillaries. Many methods are used to check the bleeding points: (1) Electrocoagulation. (2) Electric fulguration. (3) Radium. (4) Chromic acid bead. (5) Submucosal injection of sclerosing and coagulating solutions. (6) X-rays.

The following solutions have been used by various authors: (a) 5 per cent solution of quinine and ethyl carbamate, (b) 30 per cent solution of sodium chloride injected in the large telangiectases, (c) moccasin snake venom and (d) a proprietary solution of the sodium salts of the fatty acids from psyllium seeds.[2]

On the advice of Dr. Neuschatz, one of our attending surgeons, I decided to use the latter on my first case and the results were so satisfactory that I applied it successfully on the two subsequent cases. It is a 5 per cent solution of the sodium salt of fatty acids of a vegetable oil extracted from the seed of the psyllium group. It is a good fibrous tissue proliferant and sclerosing agent, widely accepted in the treatment of chronic hypertrophic rhinitis to reduce the size of the turbinal tissues. It was used successfully by Peluse[1] to control hemorrhage from the gum in his case of hereditary hemorrhagic telangiectasia.

The second part of the treatment requirement is to strengthen the walls of the capillaries with vitamin P. Vitamin P (or citrin) was developed by Szent-Oyorgyi and his collaborators who found that feeding extract of lemon peel to patients with vascular purpura had a beneficial effect where pure ascorbic acid had failed. The active principle was flavone or flavonal glucoside. At present a highly purified flavonal glucoside, with much greater activity than the original lemon peel extracts, has been obtained from the buckwheat flower and is available under the name of "rutin". I used this in two of my cases and the psyllium seed fatty acid salt[2] in all three cases. As in the case reported by Peluse,[1] "rutin" did have some beneficial influence on the frequency and character of the hemorrhages; but it was not until "sylnasol" was used that the results became satisfactory enough to make me believe

* Read at Clinical Staff Meeting at the New York Eye & Ear Infirmary, February 1948.

1. Peluse, Samuel: Archives of Otolaryngology, 44:668 (December 1946).

2. Available commercially under the trade-name of "sylnasol" (Searle).

that we had a therapy which offered some hope of relief to these patients.

CASE ONE

A 48 year old male gave the following story: eighteen years ago he began having mild sudden attacks of epistaxis, easily controlled by pressure and packs. At this time he noticed "little red blood spots" over the skin of his nose, face and cheeks. He consulted a "specialist" who operated on his nose and who said he "removed a bone".

Episodes of epistaxis continued and became more frequent until around March 1947, when he came to the New York Eye & Ear Infirmary.

Family History: A brother 55 is at present hospitalized with severe epistaxis. Telephone conversation with the doctor in charge revealed that the bleeding originated from the inferior meatus. It was the doctor's impression that this was secondary to hypertension.

Examination showed well nourished, well developed white male bleeding profusely from both nostrils, not alarmed by his condition, but pale from loss of blood.

The patient was hoarse and on being questioned said he never noticed anything unusual about his voice. He had multiple small telangiectatic spots which blanched on pressure. There were many pinpoint bright red spots on the mucous membranes of the palate, buccal surfaces and floor of the mouth. Laryngoscopy revealed a hypertrophied left false cord hiding from view of the left true cord. There was a moderate amount of yellow crusty discharge over the laryngeal structures. The skin of the tip and columella of the nose was hypertrophied, almost like a rhinophyma. Nasal mucosa was extremely dry and there was a large anterior septal perforation as well as a septal spur on the right side anteriorly. The airway was blocked by a septal bulge on the left side. Bleeding was coming from two vessels on either side of the posterior border of the perforation and also from the center of the floor of the perforation. *Sinuses* transilluminated cloudy bilaterally. Blood pressure was 130/88. Hemoglobin was 55 per cent. The erythrocyte count was 3,900,000.

Treatment at this time consisted in getting the nose dry enough to fulgurate the two bleeding points. He was given "folvron", one capsule three times a day and 20 milligrams of "rutin" twice a day, along with vitamins C and K. We also administered x-ray, 150 roentgens over the nose and face at weekly intervals.

As the weather became milder and warmer, his episodes of hemorrhage became less severe and less frequent. Within five weeks, his red cell count was up to 420,000 and the hemoglobin had risen to 77 per cent. Ten days later, the hemoglobin was 82 per cent.

The patient was carried through the summer with only mild epistaxis occurring infrequently controlled by fulguration of bleeding points. Up to early fall he had received six x-ray treatments of 150 roentgens each and daily high vitamin therapy including C, P, K, and iron. As the weather became colder, the patient again suffered severe attacks of epistaxis. This time, the blood came from a pulsating vessel on the floor of the nose half way back from the left anterior nares. This vessel was fulgurated successfully on several occasions by packing with oxycel. The patient would return the next day at which time the electric cautery could be used in a dry field. However, due to repeated episodes of loss of blood, I decided to ligate the left external carotid artery.

He entered the hospital on November 6, 1947. On the next day the left external carotid was ligated with two chromic No. 1 ties. The wound was closed with plain catgut and interrupted silk, without drain. During this period he had a recurrence of epistaxis from the same vessel on the floor of the left nasal chamber. These episodes were easily controlled by pressure and oxycel. On discharge from the hospital, he was sent for a deep x-ray treatment by Dr. Deutschberger.

He had no hemorrhage until November 26, 1947, when on one day, he had three severe nose bleeds which left him debilitated. This hemorrhage was controlled with oxycel plus an oxalic acid-phenol-malonic acid solution.[3] Next morning the erythrocyte count was down to 2,960,000 and a blood transfusion was done.

On November 29 he received 1½ cubic centimeters of "sylnasol" injected with a 3 inch 22 gauge needle in the submucosa of the floor of the nose in the vicinity of the bleeding vessel. The same amount was injected in the submucosa on the right side in the area of a bleeding vessel the next day, and three days later, another 1½ cubic centimeters were introduced into the posterior edge of the perforation where a continuous ooze was observed.

He had no more episodes of bleeding until 4 months later when he was found to have bleeding from the right and left inferior meati on the floor of the nose. He received 250 cubic centimeters of blood on March 8 and again on March 9, 1948. One cubic centimeter of "sylnasol" was injected in the submucosa on the floor of the nose on each side.

After transfusions, he had another episode of severe hemorrhage from behind the soft palate near the right Eustachian area. This was controlled by injection of "sylnasol" into the palate just medial and behind the last molar tooth and another injection near the sphenopalatine area on the right. Later, another episode of bleeding from the right inferior meatus was controlled by 1½ cubic centimeters of "sylnasol". For a year, thereafter, he was free of hemorrhage.

He reported to the clinic at intervals of two or three months. As there was always a slight oozing of blood at the margin of the septal perforation on the left, I recommended radium applications to this part of the septum. He received 1056 millicurie hours on each side of the septum on May 4 and again on May 12, 1949. Two days later he was hospitalized with severe epistaxis and secondary anemia as a result of tremendous loss of blood. His hemoglobin was now 63 per cent and the red

3. Known commercially as "Koagamin" (Chatham).

cell count was 3,560,000. A transfusion was done and the bleeding point again controlled with "sylnasol". He was discharged with a red cell count of 3,600,000 and hemoglobin of 70 per cent. He had two more brief hospital admissions which were managed the same way. The patient has had no recurrence for the past four months. He continues to take one capsule of "rutorbin" and one multiple vitamin capsule daily.

CASE TWO

On December 29, 1947, I saw a 54 year old male who complained that he had always had red spots over his cheeks, nose and lips. He reported that he had had occasional mild nose-bleeds for the past ten years, but in the past two years, they had been so frequent and severe that he had not been able to carry on his work as a farmer. He had been treated with nasal packs, oxycel, and cauterization with no influence on the recurrences of epistaxis. Two sons, one 20 and another 15, have frequent attacks of nosebleed. He had fractured his nose about five year ago. Right ear has been draining pus since childhood. Has had severe headaches on the vertex of his head and he has always had large amounts of yellow nasal discharge. *Examination* showed a badly deviated septum obstructing the right airway. Pus was seen on the floor of both nostrils. There was a spurting, pulsating, bleeding vessel on the right side of the septum in Kusselbach area. The mucosa of the anterior part of the nose was swollen and bluish-red in color. I found evidence of fresh blood in the nasopharynx with petechiae over the palate and buccal mucosa. He had spider angiomata on the nose, some on the cheeks at the mucocutaneous junction of lips and left pinna. In the right ear, there was a large perforation with granulations filling the middle ear, with thick foul white pus. Left ear was normal. The vocal cords were hypertrophied, and there was an exudate over the glottic space, and two small yellow cysts on the laryngeal surface of the epiglottis. At my initial contact, his hemoglobin was 100 per cent and red cell count was 460,000.

Radiograph studies showed a cloudy right ethmoid. The right antral mucosa was thick and the right sphenoid very cloudy. There was no evidence of bone destruction in the sinuses. The left mastoid was radiologically normal but in the right mastoid there was evidence of cell wall destruction.

He was admitted to the hospital, and received a blood transfusion, followed by application of 1½ cubic centimeters of "sylnasol" to the submucosa of the nasal septum. He also received "rutin" 20 milligrams three times a day plus vitamins and penicillin. I also instilled nose drops of penicillin with "neosynephrine".

The next day I washed the inferior meatus of the right antrum. The washings were clear. During the following week, the right sphenoid was washed three times. The first wash showed large amount of liquid white pus. Successive washes showed improvement in amount and character of pus. There was no further bleeding since his admission in the hospital and he was discharged January 5, 1948, in good condition. Nine days later he returned. There had been no bleeding since his discharge. A right sphenoid wash showed a large plug of muco-pus. Nasopharyngoscopic examination done at this time revealed nothing grossly abnormal in the nasopharynx. It was surprising to see how close to normal the mucosa of the posterior part of the nose looked in contradistinction to the anterior part which was frankly suggestive of telangiectatic areas.

He was seen again on January 26, 1948. There had been no bleeding from his nose since the last examination. Right sphenoid wash revealed only a large plug of mucus.

CASE THREE

This 20 year old male was the son of patient number 2. He had had nosebleeds since the age of 15 with no medical treatment at that time. While in the Navy, he had severe nosebleeds from both sides, and was cauterized many times but the attacks continued with progressive severity and frequency. Since his discharge from the Navy, the patient has had severe epistaxis almost every day which he controlled by packing with paper tissues. His father and brother suffer from frequent nosebleeds.

Examination revealed a well developed, well nourished white male, not bleeding at the time. There were dilated venules on Kusselbach's area on the left side of the septum, and pus in the nasopharynx. I could see small bright red spots on the buccal mucosa on the left near Stensen's papilla, and three bright red spots in the oropharynx. There was a pin-point red spot on the posterior surface of the left arytenoid. He had a spider angioma on the left lower eyelid and the right side of the nose.

Under 2 per cent pontocain topical application, 0.5 cubic centimeters of "sylnasol" were injected (by the technic described before) in the submucosa of Kusselbach area on the left. This patient has not been seen since the first examination and no laboratory work has been done.

SUMMARY AND CONCLUSION

1. A review of the literature on hereditary hemorrhagic telangiectasia is presented.

2. Three cases are presented which meet all the criteria of the clinical entity described by Osler and Rendu.

3. A method of treatment is offered, not as a cure but as an efficient and satisfactory way of controlling the hemorrhages when they occur in areas that are accessible. From the first case one gets the impression that the use of "sylnasol" as a sclerosing and hemostatic agent seemed to be less and less effective in preventing recurrence of attacks of severe epistaxis; but one thing was certain; no other method was as effective in stopping the hemorrhage, once it had started.

98 Broad Street

ARTHRITIC DERANGEMENTS OF THE HIP *

Bernard M. Halbstein, M.D., Long Branch, N. J.

Any derangement of the hip may produce an arthritis whether the background be a congenital malformation, trauma, infection, a developmental abnormality or, in fact, anything which causes a disturbance in the normal function of the joint.

The hip differs from the other ball and socket joints in the body in that it has been designed for the dual purpose of providing motion including locomotion and bearing the weight of the trunk. It must move with perfect smoothness and withstand the shocks and strains of the superimposed body weight. It can stand a great deal of insult, but should its joint surfaces be damaged it begins to work less smoothly and (though many years may elapse) the joint begins to decompensate and an arthritis results. The end result of this decompensation is an arthritic hip commonly known as coxa malum or malum coxae senilis, and is therefore the chief concern of this discussion. Other synonyms in common usage for this condition are hypertrophic arthritis, degenerative arthritis, and osteoarthritis. This multiplicity of names has occasioned slight confusion in the past, but they all refer to the same entity.

Malum coxae senilis, or osteoarthritis of the hip is the end stage of the majority of hip derangements of earlier years. Many of these hips, when their radiographs are analyzed, show the classical findings of an old Legg-Perthes disease or a slipped upper femoral epiphysis. These hips show a characteristic flattening of the femoral head with a shortening and increase in width of the femoral neck and in many instances the exact underlying condition cannot be determined, although it can be definitely narrowed down to old Legg-Perthes disease or slipped epiphysis. In recent years there has been an increasing awareness of "primary hip dysplasia". This is a predisposing condition to some cases of congenital hip dislocation and subluxation; in others, however, no clinical symptoms are noted until young adulthood or middle age when a beginning disability calls attention to a coxa malum, as a result of the mechanical incongruity of the femoral head and acetabulum.

OTHER CAUSES OF ARTHRITIC DERANGEMENTS

Rheumatoid arthritis occurs in the hip and produces great disability with its attendant pain, loss of motion and contractures. The closely related Marie Strumpell's disease affects the hips, spine, sacroiliac joints and shoulders and the hip is the most disabling of the affected joints.

The infectious diseases include tuberculosis and the suppurative arthritides. The pyogenic organisms responsible are in the main the staphylococcus aureus and albus, and the gonococcus. Adjacent osteomyelitis may cause involvement of the joint as a complication. It has been shown that pyogenic joint infection causes rapid destruction of joint cartilage and since it is a disease most common in childhood, its mechanical disability is felt in later life after an apparent recovery from the initial infection.

Trauma as an etiologic agent is important. The fractured hip is still considered the unsolved fracture in spite of the advances made in the last twenty years. Non-union, and avascular necrosis of the femoral head are still common complications and result in an arthritic derangement. A severe but fortunately uncommon condition is the traumatic dislocation of the hip with its sequela of avascular necrosis of the head.

Other causes of arthritic hip derangements which should be included in a classification are: intrapelvic protrusion of the acetabulum, otherwise known as protusio acetabuli or Otto pelvis, congenital coxa vara and true congenital dislocation of the hip. Other specific infections are encountered including pneumococcal, streptococcal, meningococcal and luetic invasion of

* Read before the Section on Orthopedics of The Medical Society of New Jersey, April 28, 1949.

the hip joint, and the fungus diseases. The Charcot joint and neoplastic diseases must be included for completeness.

HYPERTROPHIC ARTHRITIS

The diagnosis of hypertrophic arthritis of the hip is not difficult. The symptomatology is characteristic and consists of a painful or easily fatiguing hip, a gradual limitation of motion and usually some degree of deformity. Any or all of these symptoms are present in proportion to the duration and severity of the pathological process. The findings on examination reveal a flexion and adduction deformity with a decreased range of motion and pain on attempts at passive and active motion, long before the normal range is reached. These symptoms and signs are due to the hypertrophic lipping or spur formation about the hip joint, the loss of articular cartilage, or eburnation of the femoral head and the resulting muscle spasm and muscle contractures. Diagnosis is easily confirmed by x-ray. The radiographs should include the opposite hip for comparison and also the lumbosacral region of the spine, since the condition of these other regions must be known when treatment is to be considered.

The arthritic hip is to be differentiated from extra-articular conditions such as trochanteric bursitis, ileopectineal bursitis, gluteal bursitis, sciatica and psoas abscess. Frequently pain in the knee is an outstanding symptom because of the common innervation of the two joints, but when this occurs the knee joint will usually be found to be essentially negative in its physical findings.

PROPHYLAXIS

Primary hip dysplasia can be detected within the first few months of life, is amenable to simple treatment and can be cured in most instances before the child is ready to walk. Legg-Perthes disease cases should properly have complete freedom from weight bearing for a period of two to four years until the bony architecture of the femoral head is fully reestablished. Slipped epiphysis requires early surgical intervention and measures for the relief of its mechanical deficiencies. Suppurative arthritis requires early diagnosis and intensive antibiotic treatment; if diagnosis has been delayed, incision and drainage may be indicated to prevent the damaging effects of the exudate on the articular cartilage. Tuberculosis of the hip is usually treated by surgical arthrodesis so that malum coxae senilis is not a problem here, although it may develop in the opposite hip from the added strain placed upon it.

TREATMENT OF MALUM COXAE

Treatment of the fully developed malum coxae senilis is subdivided into the conservative and operative. Under conservative therapy are included the usual modalities of rest and traction, heat, weight reduction, braces, and analgesics. The intra-articular injection of procaine has given temporary relief in some instances, and manipulation under anesthesia followed by traction has been successful in giving several years of comfort to selected patients. The success of treatment depends largely on the degree of involvement, the age of the patient and the severity of the symptoms.

Operative treatment has been the only recourse in a large number of these patients. Obturator neurectomy, designed to sever the nerve supply to the hip joint has been occasionally successful in the poor operative risk and in the patient with the bilateral lesion. In unilateral involvement and in the presence of a mobile lumbar spine, arthrodesis of the hip offers the best chance of a stable, painless hip. This is especially preferred in males where a return to a work status is important. Subtrochanteric osteotomy and acetabuloplasty have yielded satisfactory results in the hands of many surgeons. Arthroplasty has been the ideal operation theoretically, but unfortunately arthroplasties in the hands of most surgeons have not stood the test of time. With a few surgeons, results have been good, but this experience is not universal. Chief obstacle has been the search for an ideal interposition substance and none of the substances used thus far have been completely satisfactory. The decision as to whether a bilateral arthroplasty, an arthroplasty on one side and a fusion on

the other, or a neurectomy on one side and one or the other of the aforementioned procedures on the other side must be tempered by the other factors of mobility or immobility of the lumbar spine, the age, physical condition, severity of symptoms and degree of pathology in each hip.

SUMMARY

The problem of arthritic derangements of the hip includes a similar group of arthritic derangements encountered in other joints of the body, with the added problem of the functions of mobility and stability required of the hip tempering their proper management. The principal challenge comes in the condition known as coxa malum or malum coxae senilis where prophylaxis is beginning to play an increasingly more important part. Unfortunately, however, a follow-up of these cases by any one surgeon will be impossible, since this covers almost a life span. The problem of treatment of the fully developed coxa malum is still an unsolved one, although much progress has been made toward its solution.

To the present time, arthrodesis has given the best results in the unilaterally involved hip; but that it has limited application is well recognized. The continued search for a method which will retain joint mobility contests any claim that arthrodesis is an ideal solution even in selected cases.

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138 Bath Avenue

AMPHETAMINE PHOSPHATE PREPARATIONS IN THE TREATMENT OF OBESITY

A CLINICAL EVALUATION

S. WILLIAM KALB, M.D., Newark, N. J.

Since 1938 when Lesses and Myerson[1] suggested that amphetamine (benzedrine) sulphate is more dependable than thyroid extract in the treatment of obesity, this drug has assumed a popular place in the armamentarium of the doctor. I have used racemic amphetamine (benzedrine) sulphate, dextro amphetamine (dexedrine) sulphate, dibasic amphetamine phosphate and monobasic amphetamine phosphate.

In February 1942,[2] November 1942,[3] and October 1943,[4] observations which were made on 500 patients, 1880 patients, and 1200 patients respectively were published. The first dealt with racemic amphetamine sulphate, the second with dextro amphetamine sulphate, propadrine hydrochloride and propadrine hydrochloride in combination with sodium delvinal. The third was an observation on 1200 patients treated with racemic amphetamine sulphate.

The present series deals with 185 patients observing the effect of dibasic amphetamine phosphate in obesity, and 325 patients who received monobasic amphetamine phosphate. These patients received from 10 to 15 milligrams of the drug twice daily for 4 to 24 weeks.

All patients were placed on a high protein diet ranging from 600 to 1500 calories depending on their original weight.

The effect on the appetite is presented in

1. Lesses, M. F., and Myerson, A.: New England J. Med., 218:119 (1938).
2. Kalb, S. Wm.: J. Med. Soc. of N. J., 39:74 (1942)
3. Kalb, S. Wm.: J. Med. Soc. of N. J., 39:584 (1942).
4. Kalb, S. Wm.: J. Med. Soc. of N. J., 40:385 (1943).

Table I. Fifteen per cent of the patients who received no medication at all showed a diminution in appetite. With dibasic amphetamine phosphate, 34 per cent developed anorexia; while 42 per cent of those receiving monobasic amphetamine phosphate demonstrated anorexia.

TABLE I

EFFECTS OF DIBASIC AND MONOBASIC AMPHETAMINE PHOSPHATE ON THE APPETITE OF OBESE PATIENTS

	No. of Patients	No change Per cent	Diminished Per cent
Dibasic Amphetamine Phosphate	185	58	34
Monobasic Amphetamine Phosphate	325	66	42
Control (Diet alone)	60	85	15

TABLE II

SIDE EFFECTS (TOXIC MANIFESTATIONS)

	185 Patients Dibasic Amph Per cent	325 Patients Mono Amph Per cent	60 Patients (Control) Per cent
Dryness of mouth	57	54	4
Insomnia	29	27	4
Palpitation	27	23	10
Halitosis	22	18	12
Dizziness	16	11	8
Weakness	15	12	16
Headache	15	13	12
Muscular pains	14	12	0
Dyspnea	11	8	1
Nervousness	10	10	4
Impotency	6	7	0

Table II summarizes the untoward side effects resulting from sub-maintenance diet alone and from those receiving the various drugs used.

Of the patients who received the sub-caloric diet alone, only a small proportion showed a sense of well-being. This emotional stimulation was prevalent to a greater degree in those who were receiving the drugs.

SUMMARY

Like all amphetamine preparations these are not ideal for the treatment of obesity. Where it is necessary to use one of them, *monobasic amphetamine phosphate* should be the preparation of choice because of the lessened side effects with this preparation compared with the others. Effect on appetite was most pronounced with monobasic amphetamine phosphate during the first two weeks of dieting in two thirds of the patients, but seemed to lose its effectiveness as the patients continued to use the drug. Incidence of anorexia dropped to 42 per cent at the end of the weight loss period. This same observation was found with all the sympathomimetic drugs except that the initial period of appetite inhibition was greater with this preparation than with the others.

Monobasic amphetamine phosphate provided fewer side reactions than the dibasic radical.

416 Clinton Place

GRADUATE PROGRAM OF HUDSON COUNTY MEDICAL SOCIETY

The Hudson County Medical Society, under the auspices of Saint Peter's College, Jersey City, announces a series of practical graduate medical courses on endocrinology, cardiology, surgical physiology and surgical physical anatomy. Lectures and demonstrations are held in the late afternoon, evenings and on Saturdays. Veterans may enroll under Public Law 346.

For detailed program write to the Division of Postgraduate Medical Program, Saint Peter's College, Jersey City 6, N. J.

CRANIAL NERVE PARESES FOLLOWING ANTI-RABIES VACCINATION

A CASE REPORT

William Rubin, M.D., and Ned Bowman, M.D., New Brunswick, N. J.

Periodically, after several rabid dogs are discovered in a neighborhood, interest in the prevention of rabies becomes aroused and control measures instituted. However, it is not well known that the prophylactic use of *anti-rabies vaccine itself can produce extensive neurologic lesions.*

Encephalomyelitis occurs in about one per cent of the cases treated with the fixed virus. Walsh, quoting Bassoe and Grinker,* listed three types of systemic involvement: (1) Ascending paralysis in which bulbar paralysis causes death in one-third of the cases affected. (2) Dorso-lumbar myelitis. (3) The neuritic form in which the oculo-motor, vagus, radial, ulnar and tenth nerves may be affected. Since third, sixth, seventh and tenth nerve pareses characterize the case to be described, it would be best to classify it with this last group of peripheral nerve lesions.

A fifty-six year old white male came to the office complaining of double vision and drooping of the eyelids of two days' duration. As a prophylactic measure two weeks before these symptoms appeared, both he and his daughter had completed the anti-rabies series (Pasteur treatment, consisting of fourteen injections of the anti-rabies vaccine.) Although neither was bitten, they both had scratch marks inflicted by the dog and his saliva contaminated several areas on the skin surface. His daughter had no signs or symptoms. The father had a bilateral blepharoptosis, more marked on the left. The left pupil was slightly more dilated than the right. Examination with the phorometer revealed 18 prism dioptres of esophoria at 30 cm. and 24 prism dioptres of esophoria at 6 meters, the cause of his diplopia for distance. He also had a slight thickness of speech.

The following day there seemed to be a loss of facial expression which eventually led to complete bilateral, peripheral, facial palsy. This, combined with partial paralysis of deglutition, as a result of vagus nerve involvement, made the taking of food difficult for several days. However, intratracheal aspiration was avoided by admitting only small quantities of food at a time. Empirically, prostigmin was administered for four days. It is of interest to observe the nerve-stimulating effect of this drug. Although the improvement would be temporary, it was definite and striking. Almost immediately after the injection of a cubic centimeter of prostigmin, the patient noticed that his diplopia for distance would disappear.

After one week, there was substantial recovery from all the paralyses. The deglutition improved, the ptosed lids were becoming elevated and the facial muscles were regaining their tone. Last to make significant permanent gain was the abducens nerve, continuing for a short time longer the annoying diplopia, especially for distance. Two weeks after the first examination there were still 18 prism dioptres of esophoria at 6 meters and 16 dioptres at 30 centimeters. Four weeks later there were 14 prism dioptres of esophoria at 6 meters and 10 dioptres at 30 cm. The diplopia had disappeared. There was no evidence of third, seventh or tenth nerve paralysis.

To diminish complications it has been recommended at the Pasteur Institute that exertion be avoided during the period of prophylactic anti-rabies vaccination. The incubation period for neurologic complications is usually ten or twelve days, whereas, in true rabies, the incubation period is three to eight weeks. Allergic individuals are more likely to develop neurologic complications from the vaccine. Where such complications are severe and occur early, suspension of anti-rabies vaccine is advisable.

For those who are too reluctant to administer the vaccine, the fact that a mortality rate of only 0.23 per cent occurs in those bitten by rabid dogs and vaccinated as compared to the expected rate of 16 per cent if they were unvaccinated must be borne in mind.

SUMMARY

1. A case of peripheral nerve involvement from anti-rabies vaccine is presented.

2. Third, sixth, seventh and tenth nerve paralyses appeared with recovery of all but the sixth nerve in two weeks. Sixth nerve recovery was practically complete in two months.

* Walsh, Frank B.: *Clinical Neuro-ophthalmology*, Baltimore, Md. (1947). Williams and Wilkins Company.

105 Carroll Place
1001 Georges Road

THE CANCER PROGRAM IN NEW JERSEY
PART V. ADMINISTRATION OF HOME CARE PROGRAM

Approved by the Advisory Committee on Cancer Control,
The Medical Society of New Jersey *

Since the organization of the New Jersey Division, American Cancer Society in 1945, it has been apparent one of the service needs of the cancer control program is the care of the terminal cancer patient. No volunteer agency can alone meet this growing problem. During the first three years of its operation, the New Jersey Division has been unable to establish a terminal care program due to the lack of funds and due to the necessity of first meeting the primary need for a network of diagnostic and therapeutic cancer clinics and for providing essential equipment and radium.

Under Part I of the Cancer Program in New Jersey, during the last three years the New Jersey Division has given financial assistance to forty general hospitals through the purchase of equipment and radium toward the expansion of the cancer clinic program.

Under Part II of the Cancer Program in New Jersey, the New Jersey Division has assisted in the establishment of a state-wide tissue diagnostic service in cooperation with the New Jersey Society of Clinical Pathologists by providing funds for the purchase of biopsy containers which have been supplied to all physicians on request.

Under Part III of the Cancer Program in New Jersey, the New Jersey Division has made the services of nurses available through the visiting nurse associations and kindred organizations, thus providing home nursing care for patients unable to pay for it from their own funds. The New Jersey Division has also provided funds for special medications for those patients and (through the activities of the women volunteers of the Division) has provided (a) dressings, (b) "loan closets" through which items or special equipment are loaned, and (c) transportation for patients.

Under Part IV of the Cancer Program in New Jersey, the New Jersey Division has financed the clerical and nursing overhead and the cost of diagnostic procedures for indigent and medically indigent patients in the cancer clinics in 44 general hospitals.

Realizing the need for an expanded service program, the society now enters into a home care program which will make it possible for county chapters to give specific aid to needy patients in their own homes or in nursing homes, over and above the aid that has been given in the past.

SERVICES UNDER THE HOME CARE PROGRAM

1. *Visiting nurse service.* Bedside care in the home provided through a Visiting Nurse Association or similar agency and paid for by the cancer society under contract on a cost per visit basis such as is provided in Part III of the Cancer Program in New Jersey.

2. *Comfort articles.* Through "loan closets", providing hospital beds, wheel chairs, rubber sheets and other equipment for the purpose of insuring adequate comfort for the patient. In addition, providing cancer dressings as has been done in the past.

3. *Special medications.* Many analgesics are too costly for the average family and can be supplied through the special medications projects already in operation.

4. *Practical nurse service.* This type of service is indicated in two instances:

(1) When full time care of the patient is essential and when such care cannot be completely financed by the family; or would force the wage earner to give up his job because of the absence of any other relative in the home to give such care.

(2) When the illness of the patient is so severe that continuous 24-hour care is necessary and the relative who has been giving this care becomes too physically or emotionally exhausted to be available both night and day. This type of nursing service should be instituted only when the life expectancy of the patient is short.

5. *Housekeeping Service.* Many patients are not ill enough to require continuous professional nursing service but they may be alone in the home while the wage-earner is at work. Combined with the visiting nurse assistance, it is helpful to employ a houseworker who can keep the home clean, prepare children's meals and perform similar services. It is difficult in many communities to find such houseworkers so the practical nurse, who does little if any housework, is the only answer to the problem. Payment for this worker depends entirely on local conditions and strict economy should be exercised at all times.

* This committee consists of Dr. William O. Wuester (chairman), Doctors James S. Gallo, William E. Bray, Joseph I. Echikson, H. Wesley Jack, Joseph H. Kler, Otto R. Holters, Frank W. Konzelmann, W. James Marquis, John L. Olpp, Nicholas M. Alter and Salvatore Giordano.

6. *Nursing Home placement.* This most costly type of service is indicated when there is no relative or friend in the home to give any care. Nursing homes can be utilized for this type of service.

Other private nursing home placement is indicated when the patient (because of the nature of the illness) requires trained professional care which cannot be obtained in the patient's home or local hospital, which may have no facilities for a patient suffering from long term illness. Various state, county and municipal agencies provide this service to eligible clients, and every source of assistance (such as old-age assistance through the county welfare board, or public assistance through the local welfare board) should be utilized whenever possible. Often, a cancer society worker can be helpful in aiding a patient to contact the proper welfare official for assistance.

Government agencies are legally responsible for aid to many cases. Where this aid is available it should be utilized and the society's proper function would be one of social rather than financial assistance.

PROGRAM TO BE APPROVED BY COUNTY COMMITTEE

The funds made available for this purpose should be spent under the responsibility, and on the authorization of, the chairman of the county executive committee, who will be expected to have investigated each applicant for home care to find out:

1. If the patient has proved cancer.
2. If the family income is such that it could not finance the needed service.
3. If every effort had been made to seek the financial assistance from the responsible government agencies.

All possibilities of government assistance at federal, state, county and municipal level should be exhausted before cancer society funds are expended; the family income must be such that it could not carry the financial burden.

RESPONSIBILITY OF PUBLIC ASSISTANCE AGENCIES

Division of Old Age Assistance, Department of Institutions and Agencies. This assistance is administered through the county welfare boards. To be eligible, a person must be 65 years of age and qualified under other requirements of the state laws. Old age assistance clients are entitled to receive medical care, visiting nurse service, medications, and (where required) nursing home care at fees set by the state department.

Old age assistance clients suffering from cancer should receive these services from the state and *not* from the cancer society. Practical nursing or services in the home can be provided by the society in these cases. However, no arrangements should be made for services to an old age assistance client without first checking with the county welfare board and fitting the cancer society program in the welfare program.

Public Assistance is administered by the municipal director of welfare under supervision of the State Department of Conservation and Economic Development. Persons under 65 without income (or whose income is less than a standard budget determined by the state department) are entitled to public assistance. As in old age assistance, necessary medical service, medications, visiting nurse services and nursing home care are provided by public funds where the person can qualify for public assistance. In these cases contacts should be made with the local welfare director and the society program should be fitted into the welfare program.

FINANCIAL PROCEDURES

Some limit must be placed upon the amount of funds spent by a county chapter for a home service program. Thus, a certain proportion of the net available funds should be allocated at the beginning of each fiscal year for this purpose. This ratio will be determined annually on a state-wide basis by the Board of Trustees or the Executive Committee of the New Jersey Division and can be revised on application of the county chapter's Board of Managers and upon approval of the state executive committee and Board of Trustees, provided the need is shown and funds are available.

Referrals: Patients in need of service may be referred by:

(a) Family physician
(b) Hospital social service departments
(c) Visiting Nurse associations
(d) Other social agencies
(e) Family or relatives

All referrals should be checked with the family doctor or the hospital to establish a definite pathologic diagnosis of cancer.

Indigency and medical indigency acceptance for assistance is based on the interpretation of these terms:

(a) *Indigency* relates to those patients who are recipients of assistance from welfare funds: old age assistance, aid to the blind, aid to dependent children (State Board of Child Welfare), general assistance (municipal department of Public Welfare) and those receiving retirement pensions.

(b) *Medical indigency* interpretation is made after determining the financial status of both the patient and his family. Medical indigency is present when a family obviously is unable to provide the funds for the necessary care for the patient, although able to maintain itself on minimum standards of living without recourse to public assistance. For instance—a family, until the moment when it comes to the attention of the American Cancer Society, may have been able to provide medical, hospital or nursing care for the patient, particularly during the beginning or acute phase of the illness, but can no longer do so because of the prolonged care indicated and the depletion of the family resources.

MECHANICS OF ADMINISTRATION

1. *Records:* All cases referred to and accepted for service by the chapter should be carefully and accurately recorded in a case record provided for this purpose. This report includes:

(a) Name, address and age of the patient.
(b) Medical report.
(c) Members of the family, age and address.
(d) Employment status of each member of the family, including the wage earned by each.
(e) Rent or mortgage payments.
(f) Amounts contributed by each wage earner to the up-keep of the patient's home.
(g) Outstanding or current debts and expenditures, including previous costs of hospital and medical care.
(h) Savings, if any.

2. *County Chapter Reports.* The county chapter will file a report on each case on the form provided by the State Division and will submit invoices properly approved by chapter officials for payment by the State Division from chapter funds, as is done for all other expenditures of the county chapter. While the Board of Trustees of the New Jersey Division has hesitated to recommend an expansion of home care service due to the lack of finances, it is now felt that (on the basis of providing a limited proporion of the funds available) some additional assistance can be given which will benefit the cancer patient. Care must be taken that a real need exists and that "luxury services" are not provided but services which conform to the normal minimum standard of living of the patient.

Too large a proportion of our revenues must not be used for terminal care to the detriment of aid for the early cancer patient.

The type of care the terminal cancer patient requires depends on the recognition of the stage of illness present at the time of application for services, so that the plan selected will be the least costly to the American Cancer Society.

3. *Home Visit Must Precede Decision on Care.* A home visit must be made by the person responsible for authorization of this type of service or by his representative. A consultation with the family physician regarding the plan of action is vital since the doctor, in many instances, knows the patient and family well and his awareness of the circumstances provides an important part in the planning of service. The importance of full use of existing cancer clinic facilities is stressed.

4. *Constructive Approach to Care.* It is important to the morale of both patient and family to avoid treating the patient as a bedridden invalid simply because of the diagnosis of cancer. In many instances the patient may be ambulatory for a long period before intensive nursing care is required and the occasional or regularly scheduled visit of the visiting nurse is as much nursing care as is necessary at the time of the opening of the case. Terminal care may require many weeks and even months of nursing service and since funds for this purpose are very limited, full knowledge of prognosis and careful planning of service will prevent needless expenditures.

Funds for terminal care are limited and if a great proportion of funds available to the American Cancer Society is used for terminal cases, no advance would be made in the general cancer control program. The American Cancer Society would then become a welfare organization eventually limited to caring for terminal cases. Until the causes and cure for cancer are found, the most important phase of the program is research and education.

315 West State Street, Trenton
790 Broad Street, Newark

MANAGEMENT OF LOWER NEPHRON NEPHROSIS FOLLOWING TRANSFUSION FOR POST-PARTUM HEMORRHAGE *

ALVIN H. KRAKOWER, M.D., and STANLEY GERSON, M.D., Paterson, N. J.

The recent literature on lower nephron nephrosis has been well summarized by Strauss.[1] We are here reporting a case in which medical management with close observation of electrolyte, fluid,[2] and acid-base balance[3] proved to be the key to recovery. In view of the recent changes in therapy regarding renal insufficiency on the basis of lower nephron nephrosis, and the success of this conservative treatment, we believe it worth while to report an obstetrical case which was so managed.

Post-partum hemorrhage is not an unusual obstetrical complication, and treatment by whole blood transfusion is universally accepted. The infrequent occurrence of anuria following shock and transfusion reaction must be recognized as due to lower nephron nephrosis.

CASE REPORT

A 21 year old white primipara at term, was admitted to the hospital November 17, 1948, in active labor. Prenatal course had been uneventful. After a seven hour labor she was delivered easily with low forceps and episiotomy under saddle-block anesthesia. Placenta and membranes were expressed apparently intact five minutes later. Ergotrate grains 1/320 was given intravenously immediately after delivery of the placenta, and followed by one ampoule of pituitrin intramuscularly. During the repair of the episiotomy it was noticed that the uterus had a tendency to relax, requiring manual massage of the fundus. Another ampoule of ergotrate was given intramuscularly before completion of the repair. The fundus was firm and one finger-breadth below the umbilicus before the patient left the delivery room. Two hours later profuse vaginal bleeding occurred with the expression of many clots. The patient went into shock. Therapy was instituted immediately and pituitrin and ergotrate administered, but the uterus had a tendency to relax under a massaging hand. The vagina was then packed. One hour later 500 cubic centimeter of Type O, Rh positive, compatible blood was started. The patient was a Type A, Rh positive. The blood was cold and given rapidly, due to the patient's poor condition. After 350 cubic centimeters had been absorbed, the patient's left lower lid became red and edematous. After an additional 50 cubic centimeters, nausea and vomiting occurred, and the transfusion was stopped. Immediately thereafter the patient had a chill, cyanosis, and labored breathing. Her temperature rose to 102. Two hours later, because of her need for blood, a half litre of Group A, Rh positive, compatible, warmed blood was introduced over two hours without untoward reaction. The patient's condition improved.

At delivery a catheterized urine specimen yielded 300 cubic centimeters. Fifteen hours after delivery, she had not voided, and at catheterization, 210 cubic centimeters were obtained. Twelve hours later a third catheterized specimen contained only 50 cubic centimeters. Seventeen hours later 90 cubic centimeters were obtained, and on the third day, 105. Urine collected during the first 24 hours following delivery was discarded, so we have no evidence of the presence or absence of hemoglobinuria. On the second day post-partum a diagnosis of lower nephron nephrosis was made, and fluids were restricted. (See Table 1.)

On the seventh day post-partum, profuse vaginal bleeding occurred. The patient was returned to the delivery room, and under aseptic technic, the vagina and cervix were visualized and pieces of tissue were removed from the uterus with a sponge forceps. These were later reported as partly necrotic decidual tissue. The uterus was packed. A transfusion of compatible whole blood was started. The patient felt chilly immediately, but there were no objective signs of a reaction until 250 cubic centimeters had been absorbed, at which time a red spot was noticed on the right cheek. The transfusion was stopped.

The oliguria continued until the eighth day post-partum at which time the urinary output increased a litre above that of the previous day. It was felt that the diuretic phase had started and attempt was made to maintain the fluid and electrolyte balance. On the ninth day because the hemoglobin was 6.5 Grams per cent 1000 cubic centimeters of a compatible blood were given in a period of ten hours with no untoward reaction. During the oliguric phase the fluid was limited, salt-free diet administered, and acidosis controlled with 15 grams of sodium bicarbonate daily. Caloric needs were maintained by the addition of protenum, vitamin B-complex and vitamin C to the diet.

The diuretic phase began on the eighth day and reached its peak on the thirteenth day. (Fig. 1) An attempt was made to keep the intake above the output, and salt was added (orally and intravenously) commensurate with the loss noted in urinary chlorides and plasma chloride levels. (Fig. II) By the fifteenth day the patient was no longer restricted as to her diet and fluid need. When diuresis was estab-

* Presented to the clinical society of Barnert Memorial Hospital, Paterson, N. J.

1. Strauss, M. B.: New England Journal of Medicine, 239:693 (December 1948).
2. Muirhead, E. E. *et al.*: The Journal of Hematology, 2:101 (February 1948).
3. Muirhead, E. E., and Hill, J. M.: Surgery, Gynecology and Obstetrics, 87:445 (April 1948).

lished, the non-protein nitrogen values began to drop.

At no time during the course of this syndrome was the systolic pressure above 130 or below 100. The blood from the original transfusion was re-checked by two additional laboratories and found to be compatible. The titre of anti A agglutinins was only 1:250. However, we must assume that the transfusion reaction was caused by these agglutinins, particularly in view of the fact that the patient's own hemoglobin was very low and the original blood was given quite rapidly.

The patient was discharged on the twentieth day. She was then clinically well and ambulatory. One week later her average daily output was 2370 cubic centimeters. Nonprotein nitrogen was 30 and hemoglobin 10 Grams per cent.

SUMMARY

A case is presented illustrating the conservative management of lower nephron nephrosis following a reaction after a transfusion for post-partum hemorrhage.

Since the writing of the original article we have treated another case of lower nephron nephrosis in an obstetrical patient; this one, however, had a different etiology. The conservative treatment with special attention to water and electrolyte balance was followed as with the first case and we were again successful. The patient recovered and was discharged ambulatory.

Day	Urine Output cc.	Fluid Intake cc.	Urine sp. gr.	Urine Cl Gms/vol	Plasma Cl mgm/100 cc.	CO2 Comb Power vol/100 cc.	N.P.N. mgm/100 cc.	Urea N Gms/100 cc. Urine	Hb Gms/100 cc.
2	140	1940	1.013	..	..	..	76	..	7.0
3	105	1920	1.012	..	..	..	..	..	..
4	123	1090	1.008	..	585	50	112	..	7.0
5	165	740	1.008	..	..	..	153	..	6.5
6	461	885	1.006	..	570	50	163	..	7.5
7	565	790	..		544	50	..	..	7.0
8	1505	981	1.008	11.5	533	57	200	..	6.5
9	3450	4195	1.006	15.5	550	55	200	0.46	..
10	4675	5612	1.005	20.0	573	55	168	0.48	10.0
11	5750	7210	1.005	27.6	597	55	153	0.37	9.0
12	7507	7305	1.006	36.0	608	58	133	0.47	9.0
13	7760	6800	1.005	42.0	608	56	103	0.38	9.0
14	6620	7280	1.007	31.0	632	54	76	0.49	9.5
15	6725	7685	1.006	25.0	632	54	68	0.59	..
16	5025	5970	1.006	14.0	597	56	62	0.73	..
17	3960	4665	1.005	11.0	..	..	..	0.80	..
18	4590	5090	1.007	11.0	573	62	47	0.78	9.0
19	4455	5032	1.007	9.4	556	63	46	0.78	..
20	3650	3980	1.009	10.0	..	..	..	0.71	8.5
27	2370	..	..	..	591	..	30	..	10.0

TABLE 1

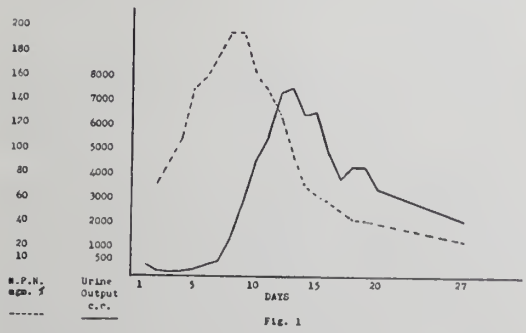

Fig. I

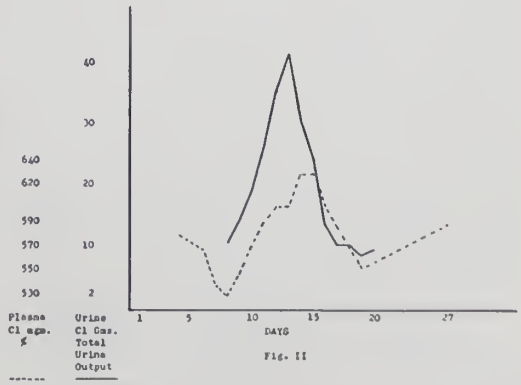

Fig. II

528 East 29th Street

HEALTH AND MEDICAL CARE PROGRAM
of
THE MEDICAL SOCIETY OF NEW JERSEY

A twelve point "cooperative health program, in which national and state governments may participate without endangering individual initiative, personal freedom or scientific progress" was announced to the public on January 30, 1950, by the Board of Trustees of The Medical Society of New Jersey.

The program was revealed by Dr. James F. Norton, President of the Society and Vice-President of the American Medical Association. In introducing the Medical Society's proposals, Dr. Norton said:

"We believe this positive cooperative health plan constitutes a 'standard to which all men of good will can repair'. We propose to seek endorsement and active support of this program from every private and public organization in the community.

"We are convinced that people working together can solve their social problems acting through the many voluntary organizations that already have accomplished so much in making life safer. healthier and happier for everyone."

The Society's recommended program, approved by the Board of Trustees on January 15, 1950, has also been endorsed by the Board of Directors of the Medical-Surgical Plan of New Jersey and by the President of the Hospital Service Plan of New Jersey.

PROPOSALS OF THE MEDICAL SOCIETY OF NEW JERSEY FOR A NATIONAL AND MEDICAL CARE PROGRAM

The Medical Society of New Jersey favors, and always has favored, a constructive approach to the solution of the national health problem, particularly as it applies to the citizens of New Jersey. The solution of medical and health problems should be undertaken in a realistic, scientific spirit. Moreover, since the health of the people transcends all political considerations, it must be considered on a nonpartisan basis.

In view of the fact that the Congress of the United States and the state legislatures are considering various extensions of the health program, the Medical Society believes that the following statement, presented as a definite and comprehensive program of action, will be helpful at this time.

The Medical Society of New Jersey believes there are large areas in which government may beneficially cooperate with the citizens, individually or acting through voluntary associations, in furthering a health program—in the interest of all the people, and without jeopardy to individual liberty. It is generally recognized that voluntary cooperative effort should have priority at all times. Government should seek to promote and supplement the efforts of free citizens, (not to supplant or supersede voluntary action) wherever voluntary cooperative effort can meet the need.

Any constructive approach to solution of the health problem must take into account the several classifications of those who require medical care, namely:

1. Those not employed but able to sustain the full cost of providing for hospital and medical care.
2. Those who are employed.
3. The "medically indigent", whose income does not suffice to meet the costs of catastrophic illnesses.
4. The totally indigent, who are on public assistance rolls.
5. The chronically ill.

Any adequate program to meet health needs should include medical and hospital care. Insofar as possible, such care should be so inclusive that everyone may budget in advance against the financial burden of sudden illness. In addition, the program should assure every community of basic health protection through well-organized professional public health departments.

No matter what program is devised. it should be experimental, flexible and evolutionary in character. It should be sufficiently concrete as to be readily understood and practically adaptable everywhere.

The Medical Society of New Jersey, therefore, offers the following proposals for a cooperative health program, in which national and state governments may participate, without endangering individual initiative, personal freedom or scienific progress. The sequence in which this program is set forth does not necessarily indicate the relative importance of its parts.

* A statement, published January 30, 1950, by James F. Norton, M.D., President of The Medical Society of New Jersey, and as authorized by the Board of Trustees of The Medical Society of New Jersey.

1. Voluntary non-profit organizations should be used as the best means of budgeting hospital and medical service for the individual and his family.

(a) The Blue Cross movement, providing for hospital care on a non-profit, minimum cost basis, is recognized as the outstanding development in this direction. First established in New Jersey less than twenty years ago, Blue Cross has extended to nearly every part of the United States. There are now 96 Blue Cross organizations with a combined enrollment of more than 35 million people. In New Jersey, approximately one-third of the population now enjoys this protection.

(b) The Blue Shield movement, launched within the past decade, has made possible the prepayment of medical care on a budget basis, which in some areas means that the doctor's bill for eligible care is covered in full for 80% of subscribers and their dependents, of whom there are now more than 12 million persons enrolled throughout the United States. Blue Shield in New Jersey has enrolled 350,000 people in only seven years.

2. For persons not employed, but able to meet the cost of enrollment in such voluntary non-profit organizations, we propose that the premiums be made eligible for deduction for income tax purposes regardless of the financial status of the subscriber or the amount of the premium paid.

Such deduction is equitable, inasmuch as employers who pay or contribute to the enrollment cost for their employees are already permitted to deduct these costs for income tax purposes, in cases where the latter enters into the computation of Federal income tax.

3. For employed groups, it is encouraging to note the growing practice of the employer contributing toward the cost of health and welfare programs for his employees and dependents. As mentioned, such payments are usually tax-deductible as part of the cost of production, and are being increasingly recognized as a legitimate part of that cost.

4. As an immediate encouragement toward employer contribution toward the enrollment cost of hospital and medical protection, government, at every level from municipal to national, should promote the program of such protection for its own employees, by assuming either a part or all of the cost of enrollment in voluntary prepayment plans.

5. As rapidly as possible, consistent with actuarial experience and sound administration, the services eligible under such voluntary non-profit organizations should be extended to cover all non-chronic ailments on an inclusive basis. An encouraging step in this direction is the decision of the Blue Shield Plan in New Jersey to provide complete coverage (within the $5000 annual income limitation) for maternity services, including delivery and pre- and post-partum care, in the hospital, the home or the physician's office.

6. After sufficient enrollment is attained, we recommend that consideration be given the practicability of providing medical care protection on an inclusive basis to subscribers in voluntary, non-profit plans, regardless of the financial status of the subscriber, and with no salary limitation for over-all inclusive service.

7. We propose that immediate study be given the possibility of providing voluntary, non-profit protection for those who are "medically indigent" though not on public assistance rolls, through the use of state and local funds for the purchase of such protection. As a rule of thumb to determine "medical indigency", the criterion might be the question whether one's taxable income is such as to exempt him from payment of Federal income taxes.

8. For the medical and hospital care of persons on public assistance rolls, we recommend the providing of service through state-county municipal funds, with such Federal aid as may be found necessary or may be provided from time to time, perhaps utilizing on a cost basis the voluntary non-profit organizations for the actual provision of the required services.

9. There is no actuarially sound basis yet established for treating the chronically ill as an insured group. We suggest, therefore, that study be given to providing care for needy persons suffering from chronic illness,on a cost basis at State level, again with the possibility of utilizing the facilities of voluntary non-profit organizations.

10. The need for better local public health service in most areas of the United States has been recognized, but progress in providing it has been discouragingly slow. We recommend that every state government—particularly our own in New Jersey—adopt such legislation as may be needed to permit consolidation of local health jurisdictions into districts having sufficient size and resources to support at least a minimum staff and facilities for complete modern basic public health protection.

11. There are numerous areas in certain states where the private practice of medicine is economically or professionally impractical, because the areas will not sustain a sufficient number of capable physicians on a fee-for-service basis, or because hospital facilities are inadequate or lacking. Progress is being made under the Hill-Burton Hospital Survey and Construction Act toward meeting the deficit of hospital accommodations. We suggest exploring the possibility of the U. S. Public Health Service providing competent physicians to such areas, when requested by State or local agencies.

12. Such a cooperative health program as is here envisaged may require a considerable increase in the number of physicians, health officers, nurses and other medical personnel. Ideally, every qualified person desiring to enter the field of medicine and public health should be able to do so. We support a program of government subsidy, where needed, to assist qualified individuals in obtaining professional training and to expand professional training facilities where it is found possible to expand existing schools or to establish new ones. In this connection we renew our plea for early action looking toward establishment of a medical school in New Jersey. We believe that any government subsidy that may be provided for these purposes

(Continued on the botton of page 86.)

ADVANCE ANNOUNCEMENT
of the
184th ANNUAL MEETING
HADDON HALL, ATLANTIC CITY, N. J.
MONDAY, TUESDAY AND WEDNESDAY, MAY 22, 23 and 24, 1950

HOTEL RESERVATIONS: A special reservation card is being mailed this week to each member. Make your reservation early; complete and forward the card promptly.

EXHIBITS: The *Scientific Exhibits* this year will be limited to New Jersey participants. Your Committee has reviewed the many applications for space received during the fall and winter, and only the best have been selected. Arrange your visit to include sufficient time to tour the Scientific Exhibits; you'll find them very worthwhile.

The *Technical Exhibits* will display the latest products and discoveries and the representatives will welcome your visit to their booths. Your Committee calls your attention to the editorial in this issue of THE JOURNAL. We have a responsibility to our technical exhibitors and we cannot stress too much nor too often their importance to the success of our annual meetings. Show your appreciation of their contribution to our meeting by touring the exhibits, stop by the booths and register and talk with the representatives. We are counting on each member to be an ambassador of good will with our friends, the Technical Exhibitors.

SECTION MEETINGS: Ten of the eighteen sections will present programs this year. The balance will participate in the 1951 meeting. Your Committee, with the approval of the Board of Trustees, set up this schedule after analyzing the 1949 meeting and the section attendance records. The section programs have been arranged for you and your Section Officers cordially invite all members to attend their sessions.

DAILY SCHEDULE

SUNDAY, MAY 21, 1950

3:00 p. m.—Registration Opens
4:00 p. m.—Finance and Budget Committee
6:00 p. m.—Dinner—Board of Trustees
8:00 p. m.—Board of Trustees
Judicial Council

MONDAY, MAY 22, 1950

9:00 a. m.—Exhibits Open
10:00 a. m.—Scientific Sections:
Surgery
Pediatrics
Eye, Ear, Nose and Throat
12:00 noon—Luncheons:
Section on Radiology
Section on Surgery
Section on Pediatrics
Section on Eye, Ear, Nose and Throat
1:00 p. m.—Auxiliary Board Meeting
2:00 p. m.—Scientific Sections:
Medicine
Obstetrics and Gynecology
Radiology
3:30 p. m.—Auxiliary Informal Tea
4:00 p. m.—Tour of Exhibits
6:30 p. m.—Auxiliary Fellowettes' Dinner
Fellows' Dinner
8:30 p. m.—Nominating Committee

TUESDAY, MAY 23, 1950

9:00 a. m.—Tour of Exhibits
9:30 a. m.—Auxiliary General Session
10:00 a. m.—House of Delegates
12:00 noon—Auxiliary Luncheon
1:00 p. m.—Tour of Exhibits
2:00 p. m.—General Session
4:00 p. m.—Tour of Exhibits
8:30 p. m.—Reference Committees

WEDNESDAY, MAY 24, 1950

9:00 a. m.—Tour of Exhibits
10:00 a. m.—Auxiliary Board Meeting
Scientific Sections:
General Practice
Gastro-Enterology and Proctology
Chest Diseases
Clinical Pathology
12:00 noon—House of Delegates (Election)
1:00 p. m.—Tour of Exhibits
2:00 p. m.—House of Delegates
5:00 p. m.—Registration and Exhibits Close
7:00 p. m.—Dinner-Dance

THURSDAY, MAY 25, 1950

10:00 a. m.—Board of Trustees

SCIENTIFIC SECTIONS
Monday Morning, May 22, 1950
10:00 a. m. — 12:00 noon

SURGERY

VICTOR B. SEIDLER, M.D., Chairman
V. EARL JOHNSON, M.D., Secretary
Vernon Room, Lounge Floor

10:00 a. m.

Surgical Lesions of the Stomach
Isidor S. Ravdin, M.D., Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia.
Discussors: Earl J. Halligan, M.D., Jersey City
Harry N. Comando, M.D., Newark

10:40 a. m.

Visit to Exhibits

11:00 a. m.

Lesions of the Colon
H. Wesley Jack, M.D., Chief of Surgery, West Jersey Hospital, Camden.
Discussors: Herbert A. Schulte, M.D., Newark
Lawrence G. Beisler, M.D., Hillside

11:25 a. m.

Differential Diagnosis of Jaundice
Frank W. Konzelmann, M.D., Director of Laboratories, Atlantic City Hospital, Atlantic City.
Discussors: William G. Bernhard, M.D., Short Hills
John L. Work, M.D., Montclair

11:50 a. m.

Business Session

PEDIATRICS

NORMAN T. CRANE, M.D., Chairman
MARTIN A. QUICK, M.D., Secretary
Rutland Room, First Floor

10:00 a. m.

The Present Status of Hemolytic Disease of the Newborn
Philip Levine, M.D., Director, Rh Testing Laboratory, Ortho Research Foundation, Raritan.

10:30 a. m.

Business Session

10:45 a. m.

Visit to Exhibits

11:00 a. m.

Brain and Liver Injury in Erythroblastosis Fetalis
Richard Day, M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York.
Discussor: Robert E. Jennings, M.D., East Orange

11:30 a. m.

Pediatrics as Not in the Book
Charles Hendee Smith, M.D., New Brunswick, Emeritus Professor of Pediatrics, New York University College of Medicine, New York.

EYE, EAR, NOSE AND THROAT

A. M. K. MALDEIS, M.D., Chairman
ALBERT F. MORICONI, M.D., Secretary
Viking Room, 13th Floor

10:00 a. m.

Consideration of Allergic Conditions from the Standpoint of the Otolaryngologist
Karl M. Houser, M.D., Professor of Otolaryngology, University of Pennsylvania School of Medicine, Philadelphia.
Discussor: Francis S. Weinstein, M.D., Newark

10:40 a. m.

Business Session

10:55 a. m.

Visit to Exhibits

11:15 a. m.

Removal of Intraocular Foreign Bodies by Anterior and Posterior Methods
A. Russell Sherman, M.D., Attending Surgeon, Ophthalmological Department, Eye and Ear Infirmary, Newark.
Discussors: James S. Shipman, M.D., Camden
Robison D. Harley, M.D., Atlantic City

Monday Afternoon, May 22, 1950

2:00 p. m. — 4:00 p. m.

MEDICINE

JEROME G. KAUFMAN, M.D., Chairman
FRANK J. ALTSCHUL, M.D., Secretary
Vernon Room, Lounge Floor

2:00 p. m.

PANEL DISCUSSION

Recent Advances in Hematology
Lowell A. Erf, M.D., Moderator, Assistant Professor of Medicine, Jefferson Medical College, Philadelphia.
Panel: Lester M. Goldman, M.D., Newark
Frank W. Konzelmann, M.D., Atlantic City
Sylvan E. Moolten, M.D., New Brunswick
Carlos A. Pons, M.D., Asbury Park

3:00 p. m.

Visit to Exhibits

3:20 p. m.

Continuation of Panel Discussion

3:50 p. m.

Business Session

OBSTETRICS AND GYNECOLOGY

HAMMELL P. SHIPPS, M.D., Chairman
JOHN D. PREECE, M.D., Secretary
Rutland Room, First Floor

2:00 p. m.

The Management of Infection in Obstetrics and Gynecology
James F. Norton, M.D., Attending Obstetrician, Margaret Hague Maternity Hospital, Jersey City.
Discussor: Edward A. Y. Schellenger, M.D., Camden

2:30 p. m.

Anesthesia in Gynecological Surgery and Operative Obstetrics
Edward B. Tuohy, M.D., Professor of Anesthesiology, Georgetown University, Washington.
Discussor: Cornelius J. Regan, M.D., Camden

3:10 p. m.

Business Session and Visit to Exhibits

3:30 p. m.

Management of Breech Delivery
Herbert Johnson, M.D., Associate Obstetrician, The Cooper Hospital, Camden.
Discussor: Robert A. MacKenzie, M.D., Asbury Park

RADIOLOGY

FRANCIS P. CARRIGAN, M.D., Chairman
BENJAMIN COPLEMAN, M.D., Secretary
Viking Room, 13th Floor

2:00 p. m.

Early Diagnosis of Cancer of the Lung
Benjamin P. Potter, M.D., Chief of Medicine, B. S. Pollak Hospital for Chest Diseases, Jersey City.
Discussor: Harry J. Perlberg, M.D., Jersey City

2:30 p. m.
Visit to Exhibits

2:50 p. m.
Radiological Treatment of Oral Cancer
William Harris, M.D., Radiotherapist, Mount Sinai Hospital, New York.

3:25 p. m.
Early Diagnosis of Cancer of the Stomach
Benjamin Copleman, M.D., Attending Roentgenologist, Perth Amboy General Hospital, Perth Amboy.
Discussor: Edward C. Klein, M.D., Newark

3:50 p. m.
Business Session

Wednesday Morning, May 24, 1950

GENERAL PRACTICE

Aaron H. Horland, M.D., Chairman
D. Ward Scanlan, M.D., Secretary
Vernon Room, Lounge Floor

10:00 a. m.
Treatment of Arthritis in General Practice
Herman H. Tillis, M.D., Assistant in Arthritis, Presbyterian Hospital, Newark.
Discussors: Harold S. Connamacher, M.D., Newark
Clarence B. Whims, M.D., Atlantic City

10:30 a. m.
Visit to Exhibits

10:40 a. m.
Heart Disease and the General Practitioner
William D. Stroud, M.D., Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
Discussors: Jerome G. Kaufman, M.D., Newark, Thomas J. White, M.D., Jersey City

11:15 a. m.
Business Session

11:30 a. m.
The General Practitioner and the Hospital
Aaron H. Horland, M.D., President, New Jersey Academy of General Practice, Newark.
Discussors: Samuel L. Kaman, M.D., Atlantic City
D. Ward Scanlan, M.D., Atlantic City

GASTRO-ENTEROLOGY AND PROCTOLOGY

Sydney Rosenthal, M.D., Chairman
Frank S. Forte, M.D., Secretary
Rutland Room, First Floor

10:00 a. m.
Malignancy in Gastric Ulcer
Louis L. Perkel, M.D., Gastro-Enterologist, Medical Center, Jersey City.
Co-Author: Leonard Troast, M.D., Adjunct Physician, Medical Center, Jersey City.
Discussor: S. Bernard Kaplan, M.D., Newark

10.30 a. m.
Business Session

10:40 a. m.
The Management of Massive Gastro-Intestinal Hemorrhage
Henry J. Tumen, M.D., Associate Professor in Gastro-Enterology, Graduate Hospital, University of Pennsylvania, Philadelphia.
Discussor: Sigurd W. Johnsen, M.D., Passaic

11:10 a. m.
Visit to Exhibits

11:30 a. m.
Modern Concepts in the Treatment of Fistula in Ano
George L. Becker, M.D., Paterson, Attending Proctologist, Midtown Hospital, New York.
Discussor: Johannes F. Pessel, M.D., Trenton

CHEST DISEASES

Juan R. Herradora, M.D., Chairman
Paul K. Bornstein, M.D., Secretary
Benjamin West Room, 13th Floor

10:00 a. m.
Extrapleural Pulmonary Resection—Evaluation of a New Procedure
Irving J. Selikoff, M.D., Paterson, Assistant Attending Physician, Sea View Hospital, Staten Island.
Discussor: Frank Bortone, M.D., Jersey City

10:25 a. m.
Interesting Cases of Chest Pathology
Harrison S. Martland, M.D., Chief Medical Examiner of Essex County, Newark.
Discussor: Irving L. Applebaum, M.D., Newark

10:50 a. m.
Business Session

11:05 a. m.
Visit to Exhibits

11:25 a. m.
X-Ray Conference—Cases of unusual interest diagnosed by panel of four chest physicians and discussed by audience.
Merrill C. Sosman, M.D., Moderator, Professor of Radiology, Harvard Medical School, Boston.

CLINICAL PATHOLOGY

William G. Bernhard, M.D., Chairman
William W. Hersohn, M.D., Secretary
Tower Room, 13th Floor

10:00 a. m.
Evaluation of Certain Hematological Procedures
Murray W. Shulman, M.D., Director of Laboratories, Veterans Administration, Newark.
Discussor: Samuel A. Goldberg, M.D., Newark

10:25 a. m.
Carcinoma of the Breast, Certain Aspects of a Five Year Experience in a General Hospital
John L. Work, M.D., Attending Pathologist, The Mountainside Hospital, Montclair.
Discussor: Arturo R. Casilli, M.D., Elizabeth

10:50 a. m.
Visit to Exhibits

11:10 a. m.
The Role of Pathology in Lesions of the Breast.
Arthur Purdy Stout, M.D., Professor of Surgery, College of Physicians and Surgeons, Columbia University, New York.
Discussor: A. Hobson Davis, M.D., Paterson

11:45 a. m.
Business Session

GENERAL SESSION

Tuesday Afternoon, May 23, 1950

2:00 p. m. — 4:00 p. m.

Vernon Room, Lounge Floor

JAMES F. NORTON, M.D., President, presiding

Two prominent speakers will present subjects of interest to all members of the medical profession. The names of the speakers will be announced later.

DINNER-DANCE

in honor of

PRESIDENT AND MRS. JAMES F. NORTON

Wednesday Evening, May 24, 1950

Vernon Room, Lounge Floor

7:00 p. m.

Welcome: Mrs. Norman Nathanson, President, Woman's Auxiliary
Dr. James F. Norton, President
Introductions: Mrs. R. John Cottone, President-Elect, Woman's Auxiliary
Dr. Aldrich C. Crowe, President-Elect

Presentation of Fellow's Key:
To: Dr. James F. Norton, President
By: Dr. J. Howard Hornberger, Immediate Past-President
Music and Entertainment

HOUSE OF DELEGATES

Presiding Officer, JAMES F. NORTON, M.D., President, Jersey City
Secretary, MARCUS H. GREIFINGER, M.D., Newark

SESSIONS

Viking Room, 13th Floor

First Session: 10:00 a. m., Tuesday, May 23, 1950

Order of Business

a. Call to Order
b. Organization of House of Delegates
c. Minutes of 1949 Meeting
d. Introduction of Delegates from Other States
e. Annual and Supplemental Reports
f. Announcements

Second Session: 12:00 noon, Wednesday, May 24, 1950

Order of Business

a. Report of Nominating Committee
b. Election

Third Session: 2:00 p. m., Wednesday, May 24, 1950

Order of Business

a. Reports of Reference Committees
b. Unfinished Business
c. Installation of Incoming President
d. Adjournment

WOMAN'S AUXILIARY

to

THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-THIRD ANNUAL MEETING

Monday, May 22, 1950

10:00 a. m.—Registration, Luncheon and Dinner Tickets
Lounge Floor
1:00 p. m.—Pre-Convention Board Meeting
Mandarin Room, 13th Floor
3:30 p. m.—Informal tea
Tower Room, 13th Floor
All physicians' wives cordially invited
6:30 p. m.—Fellowettes' Dinner (by invitation only)

Tuesday, May 23, 1950

9:30 a. m.—General Session
Mandarin Room, 13th Floor
12:00 noon—Luncheon honoring Mrs. Norman Nathanson, President
Benjamin West Room, 13th Floor

Wednesday, May 24, 1950

10:00 a. m.—Post-Convention Board Meeting
Mandarin Room, 13th Floor
7:00 p. m.—Dinner-Dance
Vernon Room, Lounge Floor

SCIENTIFIC EXHIBITS

Lounge Floor

Obstetrical Injuries to Epiphyses of Long Bones—Spencer T. Snedecor, M.D., and Harrison B. Wilson, M.D., Hackensack.

Culture and Pathogenicity of Myobacterial Forms Observed in Tumors—Virginia Wuerthele-Caspe, M.D., Roy Allen, M.D., James Hillier, M.D., James Allison, M.D., L. W. Smith, M.D., Elinore Alexander-Jackson, M.D., and Miss Marilyn Clarke, Newark.

Cytological Diagnosis—Nicholas M. Alter, M.D., R. Chesley, M.D., and E. Sattenspiel, M.D., Jersey City.

Diagnosis of Generalized Amyloidosis: Diagnostic Techniques and Criteria—Irving J. Selikoff, M.D., Paterson.

Blood Volume in Surgery—C. Abbott Beling, M.D., William G. Bernhard, M.D., George L. Erdman, M.D., Donald T. Bosch, M.D., Thomas V. Morton, Jr., M.D., Robert I. Siegel, M.D., Ladislav Stefan, M.D., and Eleanor Bonner, B.A., Newark.

Hepatic Diabetes — Carroll M. Leevy, M.D., Jacob C. Fineberg, M.D., Thomas J. White, M.D., and Angelo M. Gnassi, M.D., Jersey City.

Variation of the Normal Intestinal Bacteria in Specific and Non-Specific Conditions of the Colon—Harry Seneca, M.D., and Edward Henderson, M.D., Ph.D., Bloomfield.

Hyaluronidase in Medicine — C. E. Folsome, M.D., and H. O. Singher, Ph.O., Raritan.

Diseases of the Anus, Rectum and Sigmoid; Diagnosis and Treatment — Edwin H. Albano, M.D., and Arthur Giffoniello, M.D., Newark.

Malignant Lesions of the Left Lobe of Liver, Roentgen Manifestations — Raphael Pomeranz, M.D., Newark.

The Problem of Malignancy in Gastric Ulcer—Louis L. Perkel, M.D., and Leonard Troast, M.D., Jersey City.

Primary Carcinoma of Lung—P. J. Gianquinto, M.D., W. G. Bernhard, M.D., and L. Stefan, M.D., Newark

Perianal Infections in Tuberculous Patients (Diagnosis and Surgical Treatment) — Julius Gerendasy, M.D., Jersey City.

Carbohydrate Metabolism in Endocrine Disturbances—Rita S. Finkler, M.D., and George M. Cohn, M.D., Newark.

Precordial Electrocardiographic Technique — A. M. Lyle, M.D., C. E. Kiessling, M.D., and H. B. Kirkland, M.D., Newark.

Lesions of the Endocrine System—Samuel A. Goldberg, Ph.D., M.D., Newark.

Management of Cardiac Emergencies in Children—Harrold A. Murray, M.D., William Rumsey, M.D., and John Waldron, M.D., Newark.

Simplified Diagnosis of Congenital Heart Disease—Henry Borow, M.D., and Martin M. Maliner, M.D., Bound Brook.

Fate of Human Tissue Grafts Transplanted in Humans—Lyndon A. Peer, M.D., and John C. Walker, M.D., Newark.

Massive Hemorrhage from Upper Gastro-Intestinal Tract—Earl J. Halligan, M.D., Jersey City.

Air Borne Fungi—Preliminary Report—Nathan Schaffer, M.D., East Orange.

The Rehabilitation of the Severely Handicapped—Henry H. Kessler, M.D., West Orange.

The General Practice of Medicine and Surgery—1950—Aaron H. Horland, M.D., Newark.

Angiocardiography — William A. Leff, M.D., and Nathan J. Furst, M.D., Newark.

Constrictive Pericarditis — Henry A. Brodkin, M.D., Newark.

TECHNICAL EXHIBITS

Lounge Floor

	Booth
Lederle Laboratories, New York. N. Y.	1
Buffington's, Inc., Worcester, Mass.	2
L. & B. Reiner, Inc., New York, N. Y.	3
Kelley-Koett Mfg. Co., Covington, Ky.	4
Camel Cigarettes, New York, N. Y.	5
Doho Chemical Corporation, New York, N. Y.	6
Smith, Kline & French Laboratories, Phila., Pa.	7
Merck & Company, Inc., Rahway, N. J.	8
Sandoz Chemical Works, Inc., New York, N. Y.	9
Picker X-Ray Corporation, New York, N. Y.	10-11
Mead Johnson & Company, Evansville, Ind.	12
Ayerst, McKenna & Harrison, Ltd., N. Y. C.	13
Hanovia Chemical & Mfg. Co., Newark, N. J.	14
E. & W. Blanksteen, Jersey City, N. J.	15
Faulhaber and Heard, Inc., Newark, N. J.	16
Carnation Company, Los Angeles, Calif.	17
Ortho Pharmaceutical Corporation, Raritan, N.J.	18
M & R Dietetic Laboratories, Inc., Columbus, O.	19
Baldwin Pharmacal Co., Inc., Newark, N. J.	20
Gerber Products Company, Fremont, Mich.	21
Pet Milk Sales Corporation, St. Louis, Mo.	22
W. B. Saunders Company, Philadelphia, Pa.	23
Borden Company, New York, N. Y.	24
Holland-Rantos Company, Inc., New York, N. Y.	25

	Booth
Sarotago Spa, Saratoga Springs, N. Y.	26
U. S. Vitamin Corp., New York, N. Y.	27
Doak Co., Inc., Hyattsville, Md.	28
E. R. Squibb & Sons, New York, N. Y.	29
Wyeth, Inc., Philadelphia, Pa.	30
Eli Lilly and Company, Indianapolis, Ind.	31
Philip Morris and Co., Ltd., Inc., New York, N.Y.	32
Schering Corporation, Bloomfield, N. J.	33
Burroughs Wellcome & Co., Inc., Tuckahoe, N.Y.	34
Bristol-Myers Company, New York, N. Y.	35
White Laboratories, Inc., Newark, N. J.	36
Bilhuber-Knoll Corporation, Orange, N. J.	37
Desitin Chemical Company, New York, N. Y.	38
Mennen Company, Newark, N. J.	39
Ciba Pharmaceutical Products, Inc., Summit, N.J.	40
G. D. Searle & Co., Chicago, Ill.	41
So. Jersey Surgical Supply Co., Red Bank, N. J.	42
Winthrop-Stearn, Inc., New York, N. Y.	43
Schenley Laboratories, Inc., New York, N. Y.	44
Nestle Company, New York, N. Y.	45
Parke, Davis & Company, Detroit, Mich.	46
Coca-Cola Company, Atlanta, Ga.	47
Hoffmann-LaRoche, Inc., Nutley, N. J.	48
Cameron Surgical Specialty Company, N. Y. C.	49
Liebel-Flarsheim Company, Cincinnati, Ohio	50
Baby Service, Inc., Newark, N. J.	51
Whittier Laboratories, Chicago, Ill.	52
C. V. Mosby Company, St. Louis, Mo.	53
Upjohn Company, Kalamazoo, Mich.	54
C. B. Fleet Co., Inc., Lynchburg, Va.	55
Cosmevo Surgical Supply Co., Paterson, N. J.	56
Dy-Dee Wash, Inc., Collingswood, N. J.	57

BOARD OF TRUSTEES

JANUARY 15, 1950

The Board of Trustees met in special session in Trenton on January 15, 1950, and took the following actions:

(1) The twelve point Health and Medical Care Program of The Medical Society of New Jersey was approved (Page 74).

(2) Nomination of Dr. Elton W. Lance as a member of the Board of Governors of Medical Service Administration, to fill the vacancy created by the death of Dr. Thomas K. Lewis, was approved.

(3) Request for opinion on the corporate practice of medicine in New Jersey was referred to the Executive Secretary of the Legislative Committee for consultation with the Society's counsel.

(4) The Board concurred in the recommendation of the Society's counsel that the Executive Officer and Executive Secretary of the Legislative Committee be registered under the National Lobby Act.

(5) The Board directed that the New Jersey delegates to the A.M.A. bring before the A.M.A. House of Delegates in June the matter of reimbursement of State or County Societies for expenses incurred in the collection of A.M.A. dues to see if some arrangement can be made whereby the A.M.A. will pay the expenses incurred in the collection of their dues.

(6) The Board noted with regret the death of Dr. J. Bennett Morrison, former secretary of The Medical Society of New Jersey.

FIVE-DAY ENDOCRINOLOGY COURSE IN MIAMI

Local practitioners now have a rare opportunity to combine study with recreation by signing up for the course in endocrinology (including diabetes) to be given at the Roney Plaza Hotel in Miami Beach, April 3 to 8 inclusive. Tuition fee is $75 which covers all registration and instructional fees, except for the minor item of board and lodging in Florida. Even this will be reduced somewhat since the Roney Plaza offers its special "convention rates" to enrolees. Physician-veterans can take this course under public law 346 if they have not exhausted their benefits under that law. The only drawback is that your application must be in the hands of the secretary of the sponsoring association* on or before March 3—so better apply today if you are interested. The course is full-time, in that it covers both mornings and afternoon, but your evenings are free. A star-studded faculty of 20 prominent clinicians will be available not only for lectures and seminars but for informal talks, too. Send your application to Dr. Henry H. Turner, 1200 N. Walker Street, Oklahoma City 3, Oklahoma—and send it by air-mail, now!

* The Association for the Study of Internal Secretions in cooperation with the American Diabetes Association.

I REMEMBER PAPA

Not long ago, a member of The Medical Society of New Jersey celebrated his 50th year of practice. Perhaps "celebrated" is not the right word. He didn't do anything special that day. But he did get a letter from one of his married daughters — a sort of anniversary greeting. And he let one of his junior colleagues see the letter. That is how it came to us. We think it is worth publishing, and the recipient, who modestly refuses to be identified, has given us permission to reproduce the letter here—with changes in all names. Here it is:

Dearest Dad:

Mother said when she was basting the turkey yesterday morning, "Do you realize that on next Monday, Dad will have been practicing medicine fifty years?"

Dinner was about to go on the table, and I had to finish whipping the potatoes, so I didn't have much time to think about it then, but I've thought about it since, a lot.

You're my dad, and I love you dearly, but this that follows is something else again. I think it is as honest and as analytical an evaluation on one doctor as any daughter could manage.

As a start, I have *never* known a time when a patient has called our number and has not talked with someone who could tell him where you were, when you would be back, and what to do meanwhile. That is more than can be said of any professional call we have made by telephone ever since we married and moved away. This has been your devotion, and mother's, to what you both consider a thing of such utter importance that your entire living, for as long as I can remember, has been moulded by it, dedicated to it, and steeped in it to the utmost.

I have seen you at Sunday dinner, when a roast was brought in, and you had just begun to play Yankee Doodle with the knife and steel, put them down and go to the 'phone, listen a moment, ask a few questions and say, "Very well, I'll be right over". Mother never demurred, even faintly. It was clearly understood by all of us that you were first and foremost a physician, on whom the general public had an undisputed claim. There was the vacation which we had to stop short so that you could get back for an emergency amputation; there have been endless plans which we made as a family, which were smashed completely, and I have never seen you debate the matter, or weigh the pros and cons. Some one needed you, and you went, and it never occurred to you to drink your coffee first. I remember a light going on in your room in the dead of night, the sound of your car going out of the driveway; the sheets of your bed pulled smooth again, and hot cocoa waiting for you, and mother—who always got up when you did, and waited for you to come home,—had everything ready for your comfort. There has never been a team like you.

And the woman, whose myriad children you shepherded through measles, mumps, chicken pox, broken arms and every imaginable kind of illness,—she cried when she admitted that there was no money for the bill that had not been sent. You said something that sent her out of the office with a proud and purposeful walk. That night, one of her boys came to the back door with a covered dish—spaghetti and meat balls. You couldn't eat it. The first taste sent you pitching forward for your water glass, it was so flamboyantly spiced and seasoned, but you called her up and convinced her that no one had ever prepared a dish like it. (I'm sure no one ever had.) And the attic, crammed full of violins, gnarled canes, which you would never use, and a pathetic array of offerings in lieu of payment, which you always received and accepted with your heartfelt thanks—and you meant it. The pride you have salvaged would reach from here to Heaven.

I remember pawing through the pantry drawer for some fine twine, then watching while you tied certain surgical knots again and again. You had an operation scheduled for the next morning—you had done this bit of surgery many times, and many of those patients were back in the "hale and hearty" category again, but you never left anything to chance; you, a good sailor, who could tie knots from any position on the darkest night, in violent storms—you had to know that the nimbleness and the "know-how" were there to the utmost.

You've never lost the faculty of seeing each patient, not as a cirrhotic liver, an appendectomy, a traction splint or an arthritis, but as a person. This is going to be a hard point to make, but I think you have given more of *yourself* to what you have done, because along with the responsibility of endeavoring to make that person well again has gone the personal concern you have felt for him as an individual. Long after all that skill can do has been done, and the "x" (which you felt was God's to add to the equation) still remained undetermined, you fought for that patient in your mind and heart, and the outcome mattered to you so much, that *all of us* know how much.

I know that at certain medical schools they train their students to divorce themselves emotionally from their patients. Their theory is that no doctor can afford to give more than his very best technical knowledge to any case. The idea is that one can serve humanity better by a dispassionate attitude which keeps you unkinked emotionally, and saves your strength for the next case, whom you must see as Case Number so-and-so. But, so help me, every patient you have ever had might have been one of us, because you always added your own heartfelt "x" to what was in your brain and hands.

I have seen you come over from the office with your face all twisted up, because you had just had

to tell Mrs. A that her 13-year old daughter didn't have a glandular imbalance as she thought—she was going to have a baby. . . . or because Mr. B's specimen, which you had just examined showed, with other tests, that it was unlikely that he would see another spring. And you had that to tell him, so that he could arrange his affairs, and be ready.

When you told Mrs. A what her unmarried teenager was facing, you had spent a night thinking, "What if it were my daughter?" So you have spent a lifetime with suffering in every category, not just physical suffering, and I honestly believe that you have done more, or at least as much, for mental and spiritual suffering, as any doctor alive.

I also know that, while your practice has been rewarding in a financial sense, your thinking is such, that, an annual card from the other side of the world reading: "Successful achievements are too often overlooked or forgotten. Failure furnishes a constant theme for criticism. The wonderful skill and great devotion shown by you on March 27 of last year is hereby acknowledged, and may constant blessings attend your every effort". . . . And: "The journey to the third milestone of a transformed existence is about to begin to one grateful for the wisdom and skill of a liberator. The writer wishes you continued success and prosperity," or seeing a man whose leg you had amputated and fitted with an artificial one do a creditable clog dance around your desk, stand out in your mind as your major accomplishments. You come back from an unsolicited call on some aged woman who is now in a nursing home, and didn't think you'd remember who, or where she was; and you are as rich as Croesus, simply because her old eyes lighted up when you walked through the door, and while you could have done a number of dressings in your office during the hour you spent with her, chatting about the horse she used to ride, and what Main Street was like fifty years ago, no one could have bought that hour from you at any price. You made her happy, and that made you happy, and you can't put a decimal point in there anywhere.

Woven through all of this is mother, who scooped babies out of their baths and carried them to the 'phone when you were out on calls, or who took toddlers out to the barn to spank them, because their cries would have made it hard for you to hear a heart-beat through a stethoscope.

She had some explaining to do at times—"Why can't we have the whole gang in at two o'clock for cinnamon buns?" but she always explained office hours, that that would have to wait until four p.m., and discussed the whole business of being a doctor's family in such a way that we grew up, deferring to it and giving it a priority in our teen-age roistering.

I can't imagine what it is like to look back on half a century of doing *anything,* whether it is bending pretzels or serving humanity. (It so happens that today marks our ninth year of marriage, and Mary's seventh yesterday, and neither couple can chalk up more than just being happy, and full of plans for tomorrow). But you two have something tremendous to celebrate—50 years of unselfish living, and a record of such dimensions that no one could cover it fully. What you have done goes out in ever widening circles, of a pebble dropped in a pool, and the incredible thing about it all is that I don't suppose either of you will mark the day in any special way. Yet the ripples are there, and this is a small one coming back at you.

I can't begin to sum it up, dad—but having lived very close to your practice for a lot of years, and having lived with you as your daughter for most of the years, I guess I am qualified to say that you are something very, very special indeed. The *values* have been taught us by the one factor that put them across, and that is, a good example.

I hope I made the point, a few paragraphs back, that spiritual and moral considerations were an integral part of our thinking. To have lived with a man of your character is to have had the ultimate best.

My dearest love to you, dad,

Ethel.

CLUB ACCOMMODATIONS NOT AVAILABLE FOR FRISCO TRIP

The Pennsylvania Railroad earlier proposed that members of The Medical Society of New Jersey desiring to go to San Francisco for the A.M.A. Convention this June, arrange club accommodations in especially chartered cars. We are now informed by PRR it is impossible for them to assure us of special cars for this purpose. This is because the special car facilities of the railroad have been pre-empted by another convention. "However," PRR says, "we shall be glad to handle any individual requests forwarded to the District Passenger Agent, Traffic Department, the Pennsylvania Railroad, Newark 2, New Jersey, for the use of accommodations in regular train service."

DUES TO AMA NOW REQUIRED FOR AMA MEMBERSHIP *

Previously, any physician who belonged to his state medical society, automatically, and without additional dues payment, became a member of the A.M.A. This has been changed, and attention is called to the following:

The House of Delegates of the American Medical Association at its meeting in Washington, December 6, 1949, adopted amendments to the By-Laws of the American Medical Association whereby Division One, Chapter II, Tenure of Membership, has been changed to read as follows:

Chapter II.—Tenure and Obligations of Membership; Dues.

Section 1.—When the Secretary is officially informed that a member is not in good standing in his component society he shall remove the name of said member from the membership roll. A member shall hold his membership through the constituent association in the jurisdiction of which he practices. Should he remove his practice to another jurisdiction, he shall apply for membership through the constituent association in the jurisdiction to which he has moved his practice. Unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members.

Sec. 2.—Annual dues, not to exceed $25, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

An active member who is delinquent in the payment of such dues for one year shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

Any former member who has forfeited his membership because of being delinquent in payment of dues may be reinstated on payment of his indebtedness.

Note that the following important changes have been made:

(A) The word "Dues" has been added to the title of Chapter II.

(B) Chapter II has been divided into two sections.

(C) The first sentence of Chapter II, which read, "Membership in this Association shall continue as long as a physician is a member of a component society of the constituent association through which he holds membership," has been deleted.

(D) The words "of the American Medical Association" have been added after the word "Secretary" where clarification is necessary.

(E) The sentence, "An active member shall pay dues or assessments as may be prescribed by the Constitution or By-Laws," has been deleted.

(F) The words "in the American Medical Association" have been added after the words "shall forfeit his active membership" in the second paragraph of Section 2.

(G) The sentence forming the third paragraph of Section 2, with regard to reinstatement, is a new addition to Chapter II.

(H) A new paragraph, forming the first paragraph of Section 2, providing for annual dues not to exceed $25. has been added to Chapter II.

The House of Delegates, on recommendation of the Board of Trustees, set the membership dues for the year 1950 at $25.

The full effect of the new provisions will be developed during the next year. However, the following interpretations of the amended By-Laws are offered for guidance at this time:

(a) Active membership in the American Medical Association will continue to be limited to those members of constituent associations who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) are entitled to exercise the rights of active membership in their constituent associations as provided in Article 5 of the Constitution of the American Medical Association.

(b) A member of the American Medical Association will lose his membership in the Association when the secretary of the American Medical Association is officially informed that a member is not in good standing in his component society *or is delinquent in the payment of the American Medical Association dues established by the above change in the By-Laws.*

(c) Forfeiture of membership in the American Medical Association due to failure to pay dues will have no effect on membership in the component or constituent medical societies unless the component or constituent societies amend their respective constitutions and by-laws. *It is, therefore, possible that a physician may be a member of his component and constituent societies and at the same time not be a member of the American Medical Association.*

(d) The amended By-Laws provide for the collection of the American Medical Association membership dues by the constituent associations for transmittal to the secretary of the American Medical Association.

It is planned to provide each member of the American Medical Association a membership card and certificate of membership when his dues are paid.

It will be necessary for the secretary of the

* This material comes from information furnished by the secretary of the American Medical Association.

American Medical Association to notify members who are delinquent in the payment of their dues.

No changes have been made in the Constitution and By-Laws of the American Medical Association with respect to Fellowship. Eligibility for Fellowship and annual Fellowship dues of $12 remain the same. Under the present By-Laws a Fellow will pay for the year 1950 total membership and Fellowship dues of $37.

The following members may be exempted from the payment of the $25 American Medical Association membership dues: retired members; members who are physically disabled; interns, and those members for whom the payment of such dues would constitute a financial hardship.

OBITUARIES

MAXWELL X. COLBY

Dr. Maxwell X. Colby of Long Branch died at his home on December 18, 1949, at the age of 42.

Dr. Colby was graduated from Glasgow Medical School, Glasgow, Scotland, in 1934. He interned at Monmouth Memorial Hospital and was chief cardiologist at that institution. During World War II, Dr. Colby served as a flight surgeon.

DR. HENRY G. HOLLER

Dr. Henry G. Holler died at his home in Newark, on November 3, 1949, after a brief illness. Dr. Holler, who was 74, had practiced medicine in Newark since 1902.

He was born in Wiliamsport, Pa., and was graduated from the University of Pennsylvania in 1900. After completing additional studies at the New York Postgraduate School of Medicine he began practice in Cammal, Pa., and then came to Newark. He retired two years ago.

DR. DANIEL J. GEARY

Dr. Daniel J. Geary of Morristown, died at the New England Baptist Hospital, Boston, on December 21, 1949, after an illness of more than a year's duration.

Dr. Geary was born in Plainfield, in 1903. He was a graduate of Georgetown Medical School, class of 1927. He interned at the Robert Packer Hospital and Guthrie Clinic, Sayre, Penna., and served one year as a resident surgeon at the same hospital. He was also a resident surgeon for six months at the Manchester General Hospital, Manchester, Conn., for six months assistant resident in obstetrics and gynecology at the Jersey City Medical Center and had six months of surgical pathology at Mayo Clinic, Rochester, Minn.

At the time of his death Dr. Geary held the position of director of the Obstetrical Department of All Souls' Hospital, Morristown, which position he had filled since 1935. Dr. Geary had served as president of the medical board of the hospital, and from 1946 to 1947 was president of the Morris County Medical Society.

Dr. Geary held membership in the Society of Surgeons of New Jersey, Maternal Welfare Commission of New Jersey, and Fellowship in the American College of Surgeons. He was also a Diplomate of the American Board of Obstetrics and Gynecology.

DR. JOHN B. MORRISON

Dr. John B. Morrison, who died in California on December 14, 1949, practiced medicine in New Jersey for 40 years, twenty of them being devoted to surgery. From 1923 to 1937 he was Secretary of The Medical Society of New Jersey, retiring from this office when he moved to California.

In association with the late Dr. Samuel E. Robertson of Newark, N. J., and the late Rev. David Lusk, he helped form the Presbyterian Hospital in Newark. Finding when he settled in Newark that he could not take care of a surgical case in a hospital, he with 50 other physicians took an old closed hospital building and ran it for ten years. But the structure was not suited to their needs so with Dr. Lusk's assistance they purchased an old homestead and fitted it out for a 17-bed hospital. After 18 years of service they asked the public to subscribe $700,000 for a new hospital. The appeal brought a subscription of $1,500,000, and with $500,000 more from the Mutual Benefit Life Insurance Company, they erected what was then the finest modern hospital in New Jersey.

In 1910, together with Dr. Julius Levy, the late Dr. Edward Newman of Newark, and the late Dr. A. A. Strasser of Arlington he founded the Academy of Medicine of Northern New Jersey.

In 1937, upon retiring from the office of Secretary of The Medical Society of New Jersey, he was pensioned by that organization. He will long be remembered in New Jersey for his constructive medical work.

(This obituary was written by Dr. Morrison himself, and mailed to the editorial office in 1944, with a note asking us to place the obituary in The JOURNAL when we received news of his death. On December 16, 1949, we received that news, and published the obituary as Dr. Morrison wrote it. For 15 years he was a dynamo for our state society, and deserves a far longer obituary than this. But this is the way he wanted it.—H.A.D.)

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

In a recent issue of *Industrial Medicine* there is a discussion of the channeling to the plant medical director of the information obtained about employees through chest x-ray surveys. There is a marked difference of procedure in various localities throughout the country. In some cities it is the policy to furnish to the medical director the findings disclosed by the chest x-ray surveys and to solicit his cooperation in following-up the cases through the employee's family physician. Other localities, however, furnish this information only on request. In some places, medical directors have difficulty in obtaining the findings.

In New Jersey, the tuberculosis control program of the State Department of Health has always made a practice of sending this information to the medical director. This information is used by the physician to aid those found with suspected chest pathology and to facilitate advice as to the procedure to follow.

Occasional objection to furnishing this information to the medical director is raised by labor organizations. These objections are based on the fear that the physician will use the information to effect the discharge of employees with apparent chest pathology. This attitude is not often encountered and has no basis in fact. The tuberculosis control program believes that the plant physician is entitled to the information and endeavors, whenever possible, to see that it is received by him. Where the plant has no physician, the information is never furnished to the management. A statistical summary instead is prepared.

DR. LEVY ELECTED TO PREVENTIVE MEDICINE AND PUBLIC HEALTH BOARD

"Dr. Julius Levy, Chief of the Section on Maternal and Child Health, N. J. State Department of Health, has been elected a Founder Member of The American Board of Preventive Medicine and Public Health for having attained unquestioned eminence and having rendered distinguished service in the field of public health." This is a specialty board for practitioners of public health similar to specialty boards established for other practitioners of medicine.

WHAT IS A HEALTH OFFICER?

The October 1949 number of *Health Notes* issued by the Florida State Board of Health, is devoted to answering the question "What Is a Health Officer?" Using Dr. Robert G. Head, Jr., Director of the Jackson-Washington Counties Health Departments as a prototype, the publication describes the day-to-day activities of a county health officer. Describing the health officer's schedule for one day, the editor concludes "it is plain to see that public health is no place for a lazy man."

HEALTH EDUCATION IS COMMUNITY ACTION

Dr. Clair E. Turner, Boston, one of the world's health experts, who has visited over forty countries in Europe, Asia, Africa and South America to spread the teachings of health education, is now conducting a preliminary survey and draft for the World Health Organization on health education of the public. He writes, "The essence of health education is community action. It means different things to different people: to the public health administrator, it is a method of promoting health; to the various divisions of the Health department, it is a service; to the health educator, it is a profession; to the individual, it is a means toward more effective living, and includes all facts which favorably influence habits, attitudes and knowledge relating to individual, family, community and national health."

OUR SOCIETY'S HEALTH PLAN

(Continued from page 75.)

should be granted unconditionally to approved institutions.

The Medical Society of New Jersey Submits that through such voluntary cooperative action, the problem of attaining an adequate national health program can and will be solved. This suggested program is not extended as a nebulous proposal for the indefinite future, but might well be inaugurated within the present year.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, December 9, 1949, with Dr. M. Browne Holoman presiding.

Dr. Lowell A. Erf, assistant professor of Medicine, Jefferson Medical College, was the guest speaker. His subject was "The present status of radioactive substances and nitrogen mustard in diseases of the blood and lymph tissues". Dr. Erf gave an excellent over-all picture, in a simplified manner, of a complex and intricate subject. The relationship of radioactivity to diagnosis and treatment was ably portrayed, and the specific use of the better-known radioactive substances — phosphorus, iodine, sodium and nitrogen mustard, was discussed. The speaker stated that he believed that these elements would soon have a profound effect on the future of medicine, and that even now their potential value to medical science is inestimable.

Dr. Morton D. Ritter was elected to membership.

Dr. Nickman, speaking in reference to the collection of the A.M.A. special educational assessment for 1949, stated that a small percentage of members of this society still have not complied. He urged payment as soon as possible, and the president brought out once more, in this regard, that the assessment is not a local society ruling, but one approved and ordered by the A.M.A.

The president announced that he had received a letter from Dr. Allman who is currently attending a meeting of the House of Delegates of the A.M.A. in Washington. Dr. Allman advised that this society must get in its bid for the 1953 A.M.A. Convention as soon as possible, and accordingly made the following motion in absentia:

"That the Medical Society of Atlantic County officially extend an invitation to the Board of Trustees of the American Medical Association to hold its annual convention in Atlantic City in 1953."

Dr. Nickman announced that he has a new supply of automobile emblems on hand. These emblems are available only to regular members.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The January meeting of *Burlington County Medical Society* was held at Riverton Country Club on the 12th, with Dr. Davis, president, presiding.

The scientific portion of the program was turned over to Dr. Bernard J. Alpers, professor of Neurology, Jefferson Medical College, Philadelphia. His subject "Some Neurological Signs in General Practice" was illustrated with lantern slides. It proved to be an excellent review of some neurological problems.

Under the business portion of the program it was announced that the 1950 A.M.A. assessment bill would be sent to each member from Trenton and that checks woud be payable to The Medical Society of New Jersey.

The same assessment as last year is to be levied as Burlington County has no hospital for contagious diseases.

The boroughs in the county are attempting to designate a responsible person in each community whose job it will be to facilitate the admission of contagious cases to nearby municipal hospitals. A number of the boroughs are already carrying out this plan.

The following officers were elected for the coming year, to take office after the State Convention in May: President—Dr. R. W. Betts, President-Elect —Dr. T. B. Dickson, Vice-President—Dr. A. B. Peacock, Secretary—Dr. R. T. Buckley, Treasurer Dr. W. P. Mulford, Reporter—Dr. F. W. Metzer. Delegates to State Society—Dr. W. E. Bray, Dr. R. W. Betts, Dr. D. H. LeFavor, Dr. F. D Fahrenbruck; Alternates—Dr. Emlen Stokes, Dr. P. R. Sparks, Dr. L. E. Viteri, Dr. M. W. Newcomb, Dr. A. B. Peacock. County Nominating Committee: Dr. R. A. Haldeman (1953). State Nominating Delegate—Dr. W. E. Bray; Alternate—Dr. R. W. Betts.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

Under the chairmanship of Dr. A. M. K. Maldeis, its president, the *Camden County Medical Society* held its regular meeting on January 3, at the Dispensary Building in Camden.

Drs. Louis Ruttenberg, Max Spevack, Salvatore Siniscalco, and Louis L. Coriell were introduced to the Society after taking the Oath of Membership and signing the roll book. Drs. F. William Shafer and Paul M. Mecray, Sr., were elected to honorary membership of the Society.

This was the annual Case Report Night of the Society. Dr. A. G. Pratt presented a paper concerning birthmarks observed in a large series of cases of babies at the Cooper Hospital. Dr. E. N. Murray reviewed a very unusual case of coronary occlusion.

Dr. W. T. Read, Jr's. report of the executive committee's meeting explained the desirability of the formation of a county chapter of the New Jersey Heart Association. Dr. Walter Crist further explained this, and he moved that the society approve the formation of a Camden County Chapter of the New Jersey Heart Association.

Dr. A. M. K. Maldeis introduced Dr. James F. Norton, president of The Medical Society of New Jersey, who spoke on "The Next Phase of Our Fight Against Socialized Medicine". Dr. Norton admitted bewilderment on this question, but very cleverly incorporated many valuable and sensible thoughts and facts in his talk. He stated that he could not say or feel that our fight against socialized medicine was won, but quite definitely progress had been made and our chances are still very much alive. To further encourage and fortify our attack he pleaded that all representatives of our Society be present at the May meeting in Atlantic City.

ESSEX COUNTY

Frank S. Forte, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society,* combined with the Academy of Medicine of Northern New Jersey, was held on December 15, 1949, at the Academy of Medicine, Newark. Dr. H. A. Schulte, president of the Academy, opened the meeting with a note of welcome to all. He then turned the meeting over to Dr. J. I. Echikson, president of the Medical Society who presided.

Dr. M. H. Greifinger read the minutes of the November Council meeting which were approved as read and the actions of the Council endorsed.

There then followed a brief discussion on, "The Retirement Plan for Reservists of the Armed Forces", by August H. Groeschel, M.D., Col. Medical Reserve, Executive Officer, 315 Hospital Center.

Dr. Echikson then announced that the Male Chorus of the Essex County Medical Society would present a short program which was most enthusiastically received.

The guest speaker for the evening, Mr. Delbert Clark, educational director, N. Y. Times and former chief correspondent in Germany, was then introduced. Mr. Clark's subject was, "The New Battle for Germany".

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

The December meeting of the *Gloucester County Medical Society* was held on the evening of the 15th at the Woodbury Country Club, with the president, J. Paul Burkett, M.D., in the chair. This was a joint affair with the members of the South Jersey Dental Society being our guests.

The only business transacted was the election to full membership of William L. Hingston, M.D., of Williamstown.

The well known speaker for the occasion was Lester W. Burkett, M.D., of the School of Dentistry, University of Pennsylvania. Dr. Burkett presented a very interesting and instructive paper on "Oral Lesions—Nutritional Deficiency—Acute Herpetic Stomatitis". The talk was voluminously illustrated with excellent colored slides and from the discussion that followed it was evident that the dentists and physicians alike derived much benefit from the presentation. Dr. Burkett also showed how the physician could be of more help to the dentist and vice versa in case of oral lesions.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its third regular monthly meeting of the official year on December 6, 1949, at Murdoch Hall, Jersey City Medical Center. Dr. Butler presided.

The guest speaker was Dr. Philip Thorek, assistant clinical professor of Surgery, University of Illinois College of Medicine; associate professor of Surgery, Cook County Graduate School of Medicine; and co-surgeon-in-chief, American Hospital. Dr. Thorek's subject was *Jaundice.* A discussion from the floor followed the formal presentation; it was terminated by Dr. Thorek, who received a spontaneous rising vote of appreciation.

Following the scientific session, the meeting was addressed briefly by Mrs. Rosa P. Birnbaum, daughter of the late Dr. Berthold S. Pollak and director of X-ray Service, Hudson County Tuberculosis and Health League. Mrs. Birnbaum explained the objectives of the League and the various services it encompasses, and urged the members of the Society to familiarize themselves with the many programs sponsored by the Tuberculosis League. She distributed descriptive literature and proffered assistance to physicians who might require it.

Dr. Ginsberg, chairman of Committee on Postgraduate Medical Education, reported that his committee had received an encouraging response from the membership in general to its recent memorandum on the proposed postgraduate courses to be given this year under the auspices of St. Peter's College in Jersey City. Arrangements, he said, have been completed for courses in (1) Endocrinology, (2) Cardiology and Fluoroscopy of the Heart, and (3) Surgical Physiology.

A motion was regularly made, seconded, and carried that the Society contact local authorities in an effort to bring about much-needed preferential parking regulations for Hudson County physicians. A supplementary motion—made, seconded and carried— was to the effect that measures be taken to hav suitable identification provided for physicians' automobile license plates.

Dr. Robert L. Sperry of North Bergen was elected to membership.

MIDDLESEX COUNTY

William Winn, M.D., Reporter

The annual dinner meeting of the *Middlesex County Medical Society* was held at Oak Hills Manor, Metuchen, December 21, 1949, with about 150 members attending.

On motion moved and carried, the reports of the treasurer and the auditor were approved and accepted.

On motion the following applications for membership were accepted: Dr. Michael Brady, New Brunswick, to a two-year period of Associate membership; Dr. George Urban of Fords, to Active membership from Associate membership.

Dr. Joseph H. Kler gave a brief history of the anti-histaminic drugs and their sale as the new "cold cure" to the public. He then introduced a four-point motion as follows:

1. That the Board of Trustees of The Medical Society of New Jersey request the Federal Pure Food and Drug Administration to restrict the sale of anti-histaminic drugs in any dosage to prescriptions;

2. Publicize the inherent dangers of the indiscriminate use of anti-histaminic drugs;

3. Ask all research organizations and reputable pharmaceutical houses to join in a concerted effort to find an effective and safe method, or methods, of preventing and controlling the common cold;

4. Appoint a special committee to promote the above objectives.

We as physicians can aid in this and we all should join in this very necessary endeavor.

This four-point motion was unanimously adopted.

Election and installation of 1950 officers, Board of Trustees and Delegates and Alternates to replace those whose term expires in 1949 then followed, with the following being installed for 1950:

President—DR. H. P. FINE, Perth Amboy;
Vice-President—DR. MARSHALL SMITH, New Brunswick;
Secretary—DR. LOUIS A. PERILLO, Perth Amboy;
Treasurer—DR. GEORGE J. KOHUT, Perth Amboy;
Reporter—DR. MARTHA F. LEONARD, Highland Park.

Elected to the Board of Trustees for one year: Drs. Joseph H. Kler, chairman; R. A. Barnhardt, C. H. Calvin, M. M. Dunham, Joseph M. Gutowski, Norman Rosenberg, Sydney Smith, Jerome Ulan and J. F. Weber.

Elected to the Committee on Medical Ethics: Drs. C. W. Hoffman and Benjamin Mann for one year; Drs. F. M. Hoffman, Fannie Sender and Calvert R. Toy for two years.

Elected Delegates and Alternates to replace those whose term expires in 1949 are: Delegates—Drs. G. R. Gessner, Norman Reitman, C. H. Rothfuss, George F. Hilker, George J. Kohut, Karl Rothschild and J. A. Smith; Alternates—Drs. B. M. Howley, J. Sandella, Milton Brown, Edward Brezinski, N. B. Cole, Marshall Smith and A. Shayevitz.

1950 State Nominating Committee Delegate and Alternate: Drs. F. S. Taber and Edward F. Klein.

Dr. Clarke, the retiring president then gave the president's annual review, during which he outlined briefly the work done by the various committees and the officers working under him. He gave special thanks to Miss Kidd, office secretary, for her services to the Society. At the conclusion of his address, Dr. Clarke turned the office of the president over to Dr. H. P. Fine, the newly elected president.

Dr. Fine thanked the Society for the honor conferred upon him and he congratulated Dr. Clarke and the officers and committees serving under him for the excellent job they did. Dr. Fine then announced the appointment of Dr. S. Breslow as Field Physician for Middlesex County for 1950.

The meeting was concluded by an address by DR. GEOFFREY W. RAKE, B.S., director of the Squibb Institute for Medical Research, who gave an interesting talk on "Medical Experiences in Mexico, 1948-1949". Following questions from the floor, the meeting was adjourned.

SALEM COUNTY

John S. Madara, M.D., Reporter

At the regular monthly meeting of the *Salem County Medical Society* held at the DuPont-Penns Grove Club on October 21, 1949, two members of the society's Speakers Bureau, DRS. DAVID G. NEANDER and JOHN S. MADARA, gave sample talks on "Socialized Medicine", which ended in a lively discussion.

At the following meeting on November 18, 1949, presided over by its president, DR. J. ROBERT COX, a notice from the Salem County Health Association was read by DR. DAVID G. NEANDER, stating that a Tuberculosis Clinic would be held in the new Elmer Hospital in three or four months. The speaker of the day was DR. JOSEPH T. BEARDWOOD, JR., professor of Metabolic Diseases at the Graduate School of Medicine, University of Pennsylvania, who gave a blackboard talk on "Diabetes Mellitus" and passed out mimeographed diet lists.

SOMERSET COUNTY

Irving Klompus, M.D., Reporter

DR. MASON PITMAN presided at the regular monthly meeting of the *Somerset County Medical Society*, December 9, 1949, at the Somerset Hospital Nurses' Home.

It was voted to keep the assessment for the local society dues at the same level as last year.

Dr. Martin Tolomeo reported on the Public Relations Conference held several weeks ago in Trenton.

Dr. George Glass introduced the speaker of the evening, DR. MAURICE BRUGER, associate professor of Medicine, New York University School of Medicine. Dr. Bruger discussed "Liver Function Tests and Their Clinical Significance". He ably presented a most difficult subject and was warmly appreciated by the assembled audience.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

Under the chairmanship of DR. FREDERIC W. LATHROP, its president, the *Union County Medical Society* held its regular meeting on January 11, at the Springfield Regional High School.

By unanimous vote of the members present it was recommended that the present form of determining the number of delegates to the annual meeting be retained. It was felt that one delegate for every 15 members is a more democratic form of representation.

Martin B. O'Connor, Esq., was approved as legal counsel to the society replacing his late father who served the society for many years in this capacity.

It was decided that the members of this society participate in a hospitalization plan submitted by the Blue Cross.

There was considerable discussion regarding the $25 dues of the Americal Medical Association.

Dr. N. W. Burritt of Summit, reported on an interview with Congressman Clifford Case of this district regarding his position relative to socialized medicine. The interview was very unsatisfactory and Dr. Burritt felt that we could not rely on the support of Mr. Case.

The essayist of the evening was DR. STEWART WOLF, associate professor of Medicine, Cornell University Medical College; associate attending physician, the New York Hospital; associate visiting neurologist, Bellevue Hospital, New York City. Dr. Wolf spoke on "The Relation of Life Stress to Gastric Function in Man".

WOMAN'S AUXILIARY

SOUTH JERSEY WOMAN OF THE YEAR

Mrs. Arthur Jay Casselman was chosen the South Jersey Woman of the Year on December 1, 1949, by the Benjamin Rose Foundation, sponsor of the award. The award was a plaque and a check for $500. The citation is "In recognition of her devoted and unselfish service to the people of her community".

Mrs. Casselman is the wife of Dr. Arthur Jay Casselman. They have two children, Catherine and Arthur Jay, Jr. She was born and raised on a farm in the middle west, one of eight children. After graduation from high school she entered the Rochester (Minnesota) State Hospital School of Nursing and later became a member of the staff of the Colonial Hospital at the Mayo Clinic.

Dr. John H. Stokes became chief of the Department of Dermatology and Syphilology of the Mayo Clinic of 1916. Zula Boyd (Mrs. Casselman) was one of the two nurses chosen to head the nursing section of his department.

At the outbreak of World War I Dr. Stokes obtained permission from Dr. William Mayo to train Miss Boyd to mix and administer intravenously the old "Salvarsan". This work formerly had been done only by physicians, and this procedure established a precedent.

Dr. Stokes honored Mrs. Casselman, along with three other nurses, in a book dedication which read: "To four nurses who inspired it; quick in foresight; deft in action; wise in council; exemplars of the ministry which it seeks to teach".

On November 3, 1949, the Camden County chapter of the American Cancer Society honored Mrs. Casselman for her devotion and interest in the cancer movement.

Mrs. Casselman was given the Rose Foundation award for her work and interest in community organizations by Dr. Mary E. Roberts, the first recipient of this award. The following is quoted from the committee Citation:

Among the nominees whose names were submitted by organizations and individuals there were, literally, dozens, whose work has merited the highest praise. The process of narrowing the list was difficult. Just as there is "one glory of the sun and another glory of the moon, and another glory of the stars, and one star differeth from another star in glory," just so we rated all our candidates "stellar" in their respective orbits. But in the final analysis there was one woman whose life has been so filled with good works that with one voice the committee acclaimed as their choice the one

Who has made herself a potent factor in two-score organizations with which she has been actively identified and in many of which she has served as leader,

Whose leadership has been vital, positive and continuous,

Whose willingness to work cooperatively with the other leaders in these organizations marks her as a broad-minded woman of fine character,

Whose persistence and courage in formulating and carrying out the programs of these organizations proves her to be a woman of great strength of purpose,

Whose deep, abiding and self-sacrificing interest in and work for these organizations proves her to be a woman of broad and clear vision

Whose own life has been a convincing embodiment of the second great commandment, which is like unto the first and greatest, "Thou shalt love thy neighbor as thyself".

She has given herself to her church in loving service, as a faithful member of the church and worker in the Sunday School.

She has given herself to the educational agencies of her unit as one of the organizers and first president of the Parent-Teacher organization of Cooper School.

She has given herself to her community in organized activity for public betterment as a mem-

ber and past president of the Woman's Club of Camden, and a member of the State Federation of Women's Clubs.

She has given herself to the people of her area as an untiring worker for the Camden County Community Chest and Council of Social Agencies and as past-president of the Young Women's Christian Association.

She has given herself in war service during the period of our nation's greatest crisis as a member of the executive board of the U.S.O. and as an active worker in the Camden County Chapter of the American Red Cross.

She has given herself to the cause of public health through untold days and deeds of devotional service as a member of the executive board of the Camden County Tuberculosis Association of the New Jersey State Tuberculosis Association, as past-president of the Woman's Auxiliary to the Camden County Medical Society, as past-president of the Woman's Auxiliary to The Medical Society of New Jersey, as an effective, intelligent and dynamic worker in the American Cancer Society.

She has given herself to her family in a most unusual way, entering into their work and their avocations with absorbed attention and interest.

EXECUTIVE BOARD MEETING

Mrs. Thomas H. McGlade, Press and Publicity

Fifty-two members attended the meeting of the Woman's Auxiliary to The Medical Society of New Jersey, held on Monday, January 9, 1950, at the Society Headquarters in Trenton. It was presided over by Mrs. Norman Nathanson.

The morning session started promptly at ten forty-five and recessed at twelve-thirty for luncheon. The business included the reports of the State Chairmen and County Presidents.

The introduction of Mrs. Arthur J. Casselman, as the South Jersey Woman of the Year for 1949, took place as the session reconvened. Mrs. Casselman, upon request, gave a resume of the activities which led to her being the recipient of this Award sponsored by the Rose Foundation.

The honored guest of the day was Mrs. David B. Allman, National President of the Woman's Auxiliary to The American Medical Association. Following her greeting, Mrs. Allman stated that the New Jersey Auxiliary was alert in all its activities. She announced that she was happy to have two members of her own state on the National Board. If possible, she would like to have had more. The National Board members are Mrs. William E. Dodd, Parliamentarian and Mrs. Oswald R. Carlander, Regional Chairman of Legislation. It is the hope of Mrs. Allman that New Jersey will reach one hundred per cent of its subscription to the Bulletin. She announced that the Board of Trustees had given permission to have the Auxiliary represented on Health Organizations. In closing, Mrs. Allman urged the members to support the Auxiliary.

Mrs. Robert B. Walker, chairman of the Nominating Committee, read the suggested slate.

Mrs. Richard J. McDonald read the resolution to be sent to Mrs. Stanley H. Nichols on the death of her husband.

Delegates and alternates were nominated to attend the twenty-seventh annual meeting of the Woman's Auxiliary to the A.M.A., to be held in San Francisco, California, June 26 to 30, 1950.

AUXILIARY REPORTS

Atlantic County
Mrs. Matthew Molitch,
Chairman, Press and Publicity

A very interesting program was presented at the meeting of the *Woman's Auxiliary of the Atlantic County Medical Society* on Friday, January 13, when Mr. Fred M. Grootegoed of Fischer Flowers gave a demonstration of flower arrangements.

His deft and talented fingers quickly tuned cut flowers into beautiful centerpieces which would add grace to a dinner setting or beautify a spot in the living room. The secret of lovely flower arrangements is to use a low bowl, place a metal pincushion or chicken-wire in the center of the bowl, cover the metal with greens, place a tall flower in the center, then cut other stems in graduated sizes and place around the central flower.

A hat which Mr. Grootegoed fashioned of yellow

chrysanthemums and tulle would win the prize at any Easter parade. His corsages, dainty wristlet of garnet roses, centerpiece for Valentine's Day, brought forth "Ohs" and "Ahs" from the audience. All of the finished floral arrangements were donated by Fischer Flowers to the Auxiliary, and were, in turn, raffled off for the benefit of the Auxiliary.

The second part of the evening's program consisted of a talk by Mrs. Herbert Axilrod, chairman of the evening and of the Rural Health Program of the Auxiliary. Since a community requires a population of 50,000 taxpayers to provide an adequate medical program, the Woman's Auxiliary to The Medical Society of New Jersey has arranged a rural health program to promote better public health for rural areas. The State Department of Health gives its full support to this valuable contribution of the Auxiliary to the advancement of public health in New Jersey. Mrs. Axilrod said that she could provide six motion pictures to any group desirous of presenting them, as well as health exhibits and pamphlets.

Several important events are scheduled for the month of January for the Auxiliary. On Tuesday, Janary 24, at 1:30 p. m., the first of a series of home card parties will take place at the home of Mrs. Clarence Whims for the benefit of the Auxiliary. Co-chairmen with Mrs. Whims of this dessert card party are Mrs. Louis Rosenberg, president of the Auxiliary, Mrs. Allan Rieck, and Mrs. Edward H. Dyer. All Auxiliary members are invited to attend and should make their reservations by Monday, January 23.

The second event is planned for January 28, when the Auxiliary will hold its annual dance in the American Room of the Hotel Traymore at 9:30 p. m. The members are asked to come and bring their friends to make this affair the social highlight of the season as it has always been in the past. William Madden's orchestra will play for the dancing.

The third event will be the annual Community Day Tea which the Auxiliary holds in conjunction with the Woman's Club of Atlantic City. This year, the Tea will take place at the Hotel Strand on Tuesday, January 31, at 2:00 p. m. Mrs. G. Ruffin Stamps, chairman of Public Relations, announced that Mrs. Harry Subin, chairman of the Tea, has arranged to have Dr. James F. Norton, Vice-President of the American Medical Association speak on "Socialized Medicine—What It Would Mean to You and America". Everyone in the county is invited to attend.

Hudson County

Mrs. Arthur P. Trewhella, Press and Publicity

The annual membership luncheon and Christmas party of the *Auxiliary to the Hudson County Medical Society* was held on December 5, 1949, at Bruno's Restaurant, Jersey City. Mrs. Sydney Chayes, president, greeted the members and guests. There was no regular business session. Mrs. Chayes thanked the committee in charge of the Dinner-Dance which had been held on November 30, at the Union Club, Hoboken. About 150 had attended; novelty dances, an award of a basket of cheer and songs by Mrs. Andrew Pecoraro, an Auxiliary member, contributed to the success of a delightful evening. Among the prominent guests were: James F. Norton, M.D., president of The Medical Society of New Jersey and vice- president of the American Medical Association; Vincent Butler, M.D., president of the Hudson County Medical Society; Mr. Thomas Golden, executive officer of the Jersey City Medical Center.

New members were introduced by Mrs. John Mackin, membership chairman. Luncheon tables were set in holiday motif of red carnations accented with Christmas evergreens. Mrs. Marshall Bergen, program chairman, presented a surprise Christmas play in the form of a recorded radio sketch, entitled "Virginia's Letter to Santa Claus". Under the direction of Mr. Rick Krepela of the Jersey City Technical Institute, the cast of characters included students of the Institute and the following members of the Auxiliary: Mrs. Joseph Zbar, Mrs. Arthur Trewhella, Mrs. Euclid Ghee, Mrs. Moses Dolganos, Mrs. Sol Furman and Mrs. Irving Dershewitz. (Note: the story concerns the original letter written by Virginia O'Hanlon some forty years ago to the editor of the New York "Sun". Virginia and her parents are personal friends of our Mrs. John Nevin, past-president of the Hudson County and state Auxiliaries.)

Guests attending the luncheon were: Mrs. Norman Nathanson, president of the state auxiliary and Mrs. R. John Cottone, state president-elect. Mrs. Nathanson gave an informal talk stressing the importance of the responsibility of the doctor's wife in relation to pending legislation on *Compulsory Health Insurance*. She urged cooperation of all members in Auxiliary projects and events. She reported that our county bulletin, "The Hudsonote", had been adopted as the model for the forthcoming state publication, "The New Jersey News-Note". Mrs. Cottone greeted the members and extended her best wishes to all.

Because of the New Year holiday, the regular monthly meeting was postponed to Monday, January 9, for the *Auxiliary to the Hudson County Medical Society*. Mrs. Sydney Chayes presided. The revised constitution is to be printed in pamphlet form and is to be distributed to all members. Plans are under way for a card party to be held on February 17 for the benefit of our Welfare Fund. A Nominating Committee was appointed in anticipation of the April election of officers.

Following members attended the State Auxiliary meeting in Trenton on January 9: Mrs. Francesco Figurelli, Mrs. Arthur Trewhella, Mrs. Vincent Campana, and Mrs. Andrew Pecoraro.

Members participated in a demonstration lesson in the art of decorating glassware. Refreshments were served after the painting lesson.

BOOK REVIEWS

Essentials of Gynecologic Endocrinology. By Gardner M. Riley, Ph.D. Pp. 205. Ann Arbor, Caduceus Press, 1948.

This excellent little book, to quote the author, "is designed as a source of endocrine information for medical students, interns and those of the medical profession whose daily lot it is to deal with the vagaries of male and female gonadal function". The author has limited himself largely to describing the effects of hormonal agents on the human reproductive tract, omitting detailed descriptions of laboratory studies on animals. He has also eliminated a great deal of the controversial and speculative ideas which abound in the literature. Result, is a well organized presentation of endocrine gland physiology, useful diagnostic procedures, and accepted forms of hormonal therapy.

Of special interest to the gynecologist is the chapter covering menstrual dysfunctions which offers methods of classifying the functional amenorrheas as well as functional uterine bleeding—two subjects which are usually discussed only superficially in the average text book. Dr. Riley also describes the endocrine therapy of these conditions in detail. Another chapter is helpful in organizing the confusing array of commercial endocrine preparations now available into general chemical types, sources, methods of administration and relative potency. There is also a very fine chapter in which are described the complete details of laboratory procedures such as Papanicolaou's smear staining technic, modifications of the Ascheim-Zondek test, and other important diagnostic aides.

This book is well worth more than a passing glance to anyone who deals with gynecologic problems.

SYLVIA F. BECKER, M.D.

Clinical Audiology. By Maurice Saltzman, M.D. Pp. 195. New York, Grune & Stratton, 1949. ($5.00)

Audiology has made tremendous strides in the last ten years due to the impetus of the last war and the advances made in the surgery of deafness. This book contains a discussion of sound and noise; the physiology of hearing; the nature of deafness; hearing tests and hearing aids. The print is readable and the format good but the bibliography is rather brief.

Dr. Saltzman has written a clear exposition which will prove a boon to those otolaryngologists who have been confused by the mass of detail and confused nomenclature found on this subject. The book will be a stepping stone to more advanced volumes. *Clinical Audiology* is on a rather elementary plane and eminently suited to the resident and postgraduate student but it will certainly not replace the larger, more complete, and more authoritative monographs on the subject.

References to newer concepts are lacking or at most receive scant attention. The work of Wever and Bray is merely alluded to; the theories of McNaughton-Jones are not mentioned. Caloric testing in relation to hearing problems is given one paragraph. The work of Bekesky is omitted; the Tullio phenomenon is not mentioned.

It is unfortunate that Dr. Saltzman (who evidently wrote this book for the clinician) failed to give the practicing otologist practical aid in the office management of hearing problems. Nowhere does the author tell us why or how or with what. He gives no specific or detailed instructions on how to use an audiometer; how to sound-treat a room. He neglects to tell us how actually to do speech testing. He fails to tell his reader how to pick practically the best hearing aid. This book definitely does not answer the need of an otologist requiring practical definitive information on audiology.

HENRY Z. GOLDSTEIN, M.D.

Shearer's Manual of Human Dissection. Edited by Charles E. Tobin, Ph.D. 2d ed. Pp. 286. Philadelphia, The Blakiston Company, 1949. ($4.50)

This manual is especially useful for those engaged in graduate or post-graduate anatomic studies. Its primary use is for the study of anatomy by medical students. However, with the decrease in time allotted for gross anatomy study in medical school, this manual will facilitate and enhance instruction. It has achieved a workable balance between the amount of procedure for dissection and descriptive text. It is a compromise between the classical, lengthy manuals and the very brief dissection guides. It is adaptable to various plans or sequences of dissection and to dissection of only small parts in which the dissector is interested. Designed to be an autonomous unit, the manual does not have to be used in conjunction with, or with reference to, any descriptive text. However, the information gained from the dissection and from the brief descriptions and illustrations should be supplemented by collateral reading in one of the standard descriptive texts.

The value of the first edition has been enhanced by certain changes and illustrations designed to accomplish the following purposes: (1) Maintain the original plan so that the manual can be adapted to any sequence of regional dissection. (2) Give the dissection procedure for the entire body and yet keep the dissected parts in as near their normal relationships as possible, so that relationships as well as individual parts can be studied. (3) Change the dissection procedure to show certain structures to better advantage. (4) Add the dissection procedure for regions which had not been covered previously. (5) Reorganize the text descriptions where they were considered too detailed for a manual of human dissection. (6) Add illustrations to supplement the original text or to illustrate changes in dissection procedure. (7) Make the more important structures on each page more easily recognized by printing them in bold face type. (8) Introduce new anatomic concepts developed since the first edition was written.

STUART Z. HAWKES, M.D.

Book Reviews continue on next page.

Therapeutic Exercises. Hans Kraus, M.D. Pp. 336. Charles C. Thomas, Springfield, Illinois. 1950. ($6.50)

After medical and surgical measures have achieved their maximum effect, any subsequent rehabilitation is accomplished by training and retraining the remaining muscles. One of the prime tools for this training is the therapeutic exercise. This is a process in which there is a good deal of vagueness, faddism and amateur tampering. While realizing that the supervision of physical exercise is the duty of the physician, most doctors really can not do effective supervision over rehabilitation. Here is a book which will help the practitioner understand both the principles and practices of therapeutic exercises. It covers specific technics, theoretical principles, the writing and execution of an "exercise prescription" and the practical application of exercise therapy to specific clinical conditions. It is well illustrated, down-to-earth, realistic, and covers an area not precisely covered by any other modern medical text.

Herbert Boehm, M.D.

Public Health Statistics. By Marguerite F. Hall, Ph.D., New Jersey State Department of Health. 2d ed. Pp. 441. New York, Paul B. Hoeber, Inc., 1949. ($7.50)

This book combines both research and practical health department statistics. The text is full of pertinent data which refreshes the statistically inclined reader and act as a guide to the health department statistician.

An excellent discussion of the punch card should stimulate administrators to use it regularly in health departments. A readable chapter on tabular presentation shows how to set up tables.

A unique contribution of this book is the discussion of nomograms or short cuts to statistical procedures such as the computing of rates. A nomogram for computing rates is enclosed with each book. Health department statisticians will save time if they will use this nomogram routinely. The chapter on graphic presentation, adequately depicts the various types of charts, including the use of arithmetic ruled paper and logarithmic ruled paper.

Vital Events is a descriptive title for the chapter on registration of births, deaths, stillbirths, and illnesses. The new stillbirth certificate is shown. Dr. Hall describes the functions of the International List of Causes of Death, the Physicians' Handbook on Birth and Death Registration, and the Manual of Joint Causes of Death in producing comparability of mortality statistics.

The usual definitions of rates and how to calculate them are given. The author is to be commended for the simple formulae she uses in calculating the significance of the difference between two rates. These formulae enable the statistician to determine whether differences between rates are merely chance variations attributable to sampling.

The latter part of this book is the paradise of the statistician. It deals with such data as life tables, the binomial theorem, the properties of the normal curve, measures of reliability, correlation and sampling. The annual reports of health departments would be much improved if a standard error of a rate, chi-square tests or correlation coefficients were inserted in accordance with the theory expressed in this book. However these data are now used extensively in psychology, pharmacology, statistical research, life insurance, and economics.

The appendix contains 388 formulae for quick reference for computations.

Dr. Hall is Director of the Bureau of Vital Statistics and Administration of the New Jersey State Health Department. She is to be congratulated for an excellent book that should be in the library of every health department.

Henry Simon, M.D., Dr. P. H.

Clinical Diagnosis by Laboratory Examinations. By John A. Kolmer, M.D. 2d ed. Pp. 1212. New York, Appleton - Century - Crofts, Inc., 1949. ($12.00)

This comprehensive book will find a useful place in the library of every alert physician. The text covers indications for laboratory examinations in all phases of medical practice. It includes the clinical interpretation of laboratory examinations with much needed emphasis on the normal values of all the tests described. Dr. Kolmer summarizes the important laboratory findings in specific diseases of various organs and systems such as the blood and hemopoietic, the kidneys and urinary tract, venereal diseases, disorders of metabolism and so on. The author points out the series of tests advisable for making or excluding a clinical diagnosis. At all times, Dr. Kolmer displays a conservative attitude toward the evaluation of the role of laboratory examinations in the overall clinical picture. A 146 page section is devoted to the technic of laboratory examinations so that, in a sense, it is a practical laboratory manual.

The present edition has been heavily revised by the inclusion of much recent material. Mention should be made particularly of a discussion of the value of acid phosphatase determination; new tests for liver function including encephalin cholesterol flocculation, thymol turbidity, and prothrombin determination; the role of Rh factors and anti-Rh agglutinins and "blocking antibodies" in relation to pregnancy and blood transfusion; the cold agglutinin test in primary atypical pneumonia; and the specificity and sensitivity of serologic tests and cardiolipin antigen in the diagnosis of syphilis.

A most valuable feature of this book is the group of tables summarizing the essentials of each chapter. The index is unusually complete and the use of bold face type for section headings is commendable.

Gabriel Yelin, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **February, 1950** **No. 2**

"HOW can we provide effective nursing care in tuberculosis sanatoria?" World War II, with its accompanying dislocation in medical and nursing services, focused attention sharply upon the problem of general nursing and tuberculosis nursing in particular. It is time to review these problems in the light of postwar conditions and the circumstances which may be expected to arise in years to come.

EFFECTIVE NURSING CARE FOR THE TUBERCULOUS

Throughout the field of nursing there is a deficit of workers, and nursing needs have increased in spite of lower death rates, longer life expectancies, and a healthier population. The increase in population, with more people in older age groups, the higher standards of living, and the expansion of medical prepayment plans, have swelled the demand for hospital beds.

An acute deficit of nurses exists in the field of tuberculosis which still accounts for more than 5 per cent of all the days spent in hospitals in this country. In 1948, more than five thousand graduate nurses, and, almost twice as many nonprofessional auxiliaries were employed to care for patients with tuberculosis.

Unfortunately, many hospitals are so badly understaffed that nurses cannot give time to the niceties of care. Tuberculosis, because it is chronic and communicable, is a serious dislocation in the life of a patient. In addition to medical treatment, a patient in a hospital needs to have a sense of being cared for without strain and worry, but today, a nurse is often too rushed to give the care which will foster this sense. If the pressure and haste, the mechanization of nursing, can be eliminated, many more young women will wish to enter the profession.

In tuberculosis hospitals, the nurse is likely to be even more pressed for time than in general hospitals. The recommended standards for nursing services in tuberculosis hospitals has long been the following: 3.3 bedside nursing hours per 24 hours per bed-surgical patient; 2.7 bedside nursing hours per bed-medical patient; 1.5 bedside nursing hours per semi-ambulant patient; 0.5 bedside nursing hours per ambulant patient. In practice, almost no tuberculosis hospital has been able to employ enough nurses to meet such a standard.

One source of a nurse's satisfaction in her work has always been the sense of sharing the scientific understanding and confidence of the doctor in the treatment of the patient. The doctor who makes the nurse a member of the medical team, who gives her respect and consideration, who is aware of her contribution, and gives her recognition, helps to make nursing a more attractive profession.

Salary is not the nurse's primary consideration. Yet it should be mentioned that nurses' salaries have not risen in relation to the cost of living, and tuberculosis hospital salaries have not kept pace with gradual increases in salary scale in general hospitals.

A more careful observance of safe techniques in guarding tuberculosis nurses against infection will undoubtedly attract more women to this branch of nursing. Before being assigned to a tuberculosis service, a nurse should have a general physical examination, a chest X-ray, and a tuberculin test. Each of these procedures should be repeated at intervals. Many authorities also recommend BCG vaccination for nonreactors to tuberculin. But few tuberculosis hospitals give nurses

routine preemployment physical examinations, and some even omit tuberculin tests, although preemployment X-ray is almost universal.

Nurses assigned to tuberculosis services after passing a physical examination with a chest X-ray, must be protected on the job. Wherever better care of tuberculous patients has been demonstrated, and better protection for workers has been made easily accessible, it has become easier to recruit and retain personnel.

Improvements in recreation and transportation can also help to increase the inducements of tuberculosis nursing. The trend toward building new tuberculosis wings and hospitals close to general medical facilities will undoubtedly make it possible for additional nurses to enter tuberculosis nursing.

More students will also enter tuberculosis nursing if they receive better instruction and are provided with a safer environment in which to practice. In 1946, only 24 per cent of all schools of nursing offered clinical experience in tuberculosis.

There is an increasing acceptance of minority groups and of men in nursing schools and in the profession. If tuberculosis nursing is made attractive enough, it will draw its share of both sexes and from minority groups.

Up to now there has been almost no systematic analysis of the jobs to be done in a tuberculosis hospital. The present haphazard job "system," with overlapping duties for graduate nurses, practical nurses, aides and orderlies, leads to inefficiency. *Job analyses are urgently needed.* Every hospital should try to use the talents and training of its workers as efficiently as possible.

What then can be done to increase the number of nurses for tuberculosis nursing services in the United States? As has been pointed out, many positive steps can be taken: increasing job satisfaction, better precautions against infection, better instruction of nurses and auxiliaries in tuberculosis nursing, salary adjustments, better hours, increased employment of members of minority groups, job analyses, better utilization of time.

Although it is not inevitable that nursing care will become better as the number of nurses increases, yet the quantity of nurses is considered one index of the quality of patient care. If our society can provide enough nurses to staff its hospitals adequately, each nurse will strive to give the kind of patient care for which she has dedicated herself to her profession. Tuberculosis hospitals, if they keep pace with developments, will share in the improvement of nursing services everywhere.

Effective Nursing Care for the Tuberculous, Chesley Bush, M.D., Esta H. McNett, R.N., B.S., Lucile Petry, M.A. and Martha B. Naylor, R.N., B.S., Public Health Reports, August 5, 1949.

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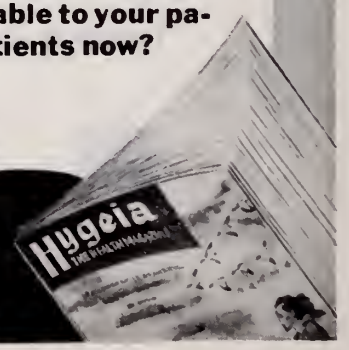

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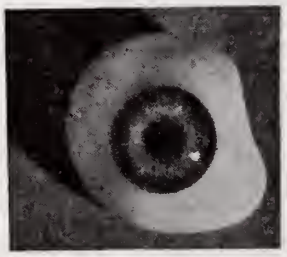

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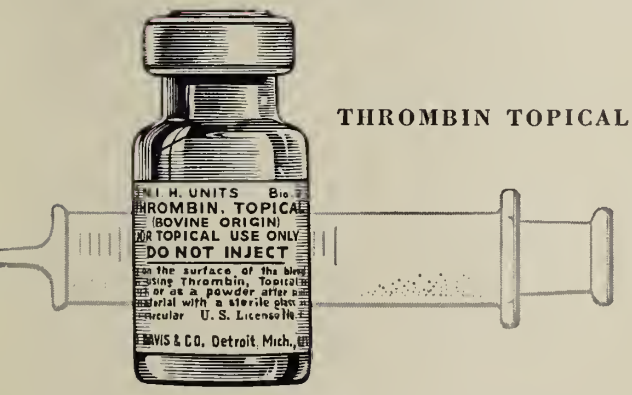

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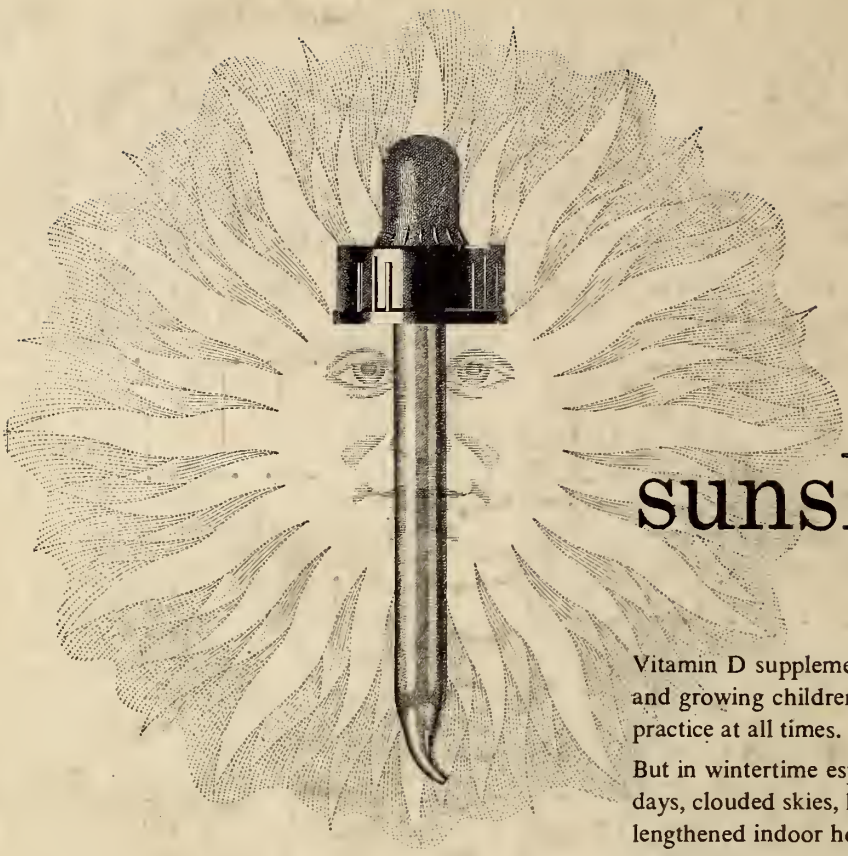

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CONTENTS—Pages 97 to 144

EDITORIALS— Page

New Jersey's Health and Medical Care Plan 97
The Semantics of Cancer 98
Governor Endorses New Jersey Health Plan 99

ORIGINAL ARTICLES—

Present Aspects of Melanomas — Samuel Goldberg, M.D., West Orange, N. J. 100

Treatment of Arthritis With "Anathion"—Leon Libenson, Ph.D., Flemington, N. J., and William F. J. Wittenborn, M.D., Trenton, N. J. 105

The Muscle Pains of Asthma—Samuel Gordon, M.D., Paterson, N. J. 110

Otogenic and Tuberculous Meningitis—Bela Steiner, M.D., Budapest, Hungary, and Joseph Lang, M.D., Perth Amboy, N. J. 112

Avulsion of the Distal Biceps Brachii Tendon—Raphael R. Goldenberg, M.D., Paterson, N. J. 114

Diagnostic Errors in Diabetes — Benjamin Saslow, M.D., Newark, N. J. 116

Mass Chest X-Ray and Follow-up—Irving Willner, M.D., Newark, N. J. 120

ORIGINAL ARTICLES— Page

Uterine Suspension—M. Edward Baker, M.D., Camden, N. J. 123

Dental Crown in Nasopharynx Following Endotracheal Anesthesia — I. M. Schnee, M.D., Paterson, N. J. 124

STATE ACTIVITIES—

Bergen County Graduate Courses 111
Amputee Conference 111
Graduate Courses in Washington 115
EENT Seminar 115
Essex County Doctors' Chorus 125
Control of Poliomyelitis 126
Care of Psychiatric Patients in General Hospitals 127
With New Jersey Medical Authors 129
Preview of Pharmacopoeia Changes 138

OBITUARIES 130

VIEWS AND REVIEWS 131

COUNTY SOCIETY REPORTS 134

WOMAN'S AUXILIARY 139

BOOK REVIEWS 141

TUBERCULOSIS ABSTRACTS 143

Roster of Officers, Advertising Page 3 A

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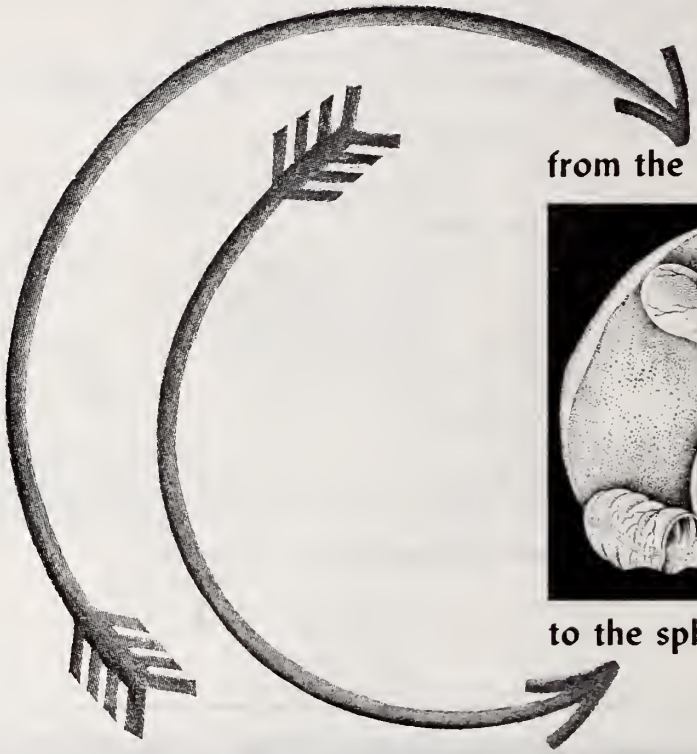

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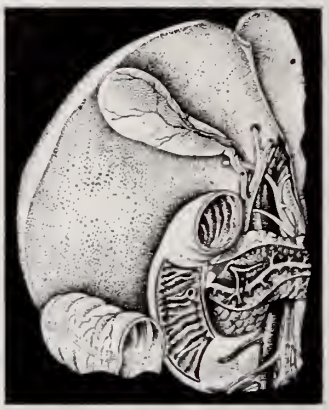

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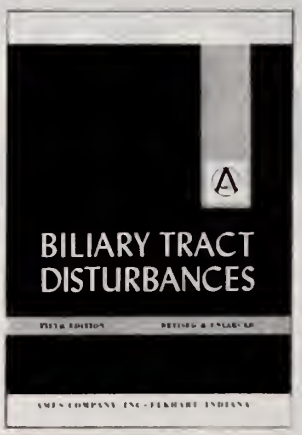

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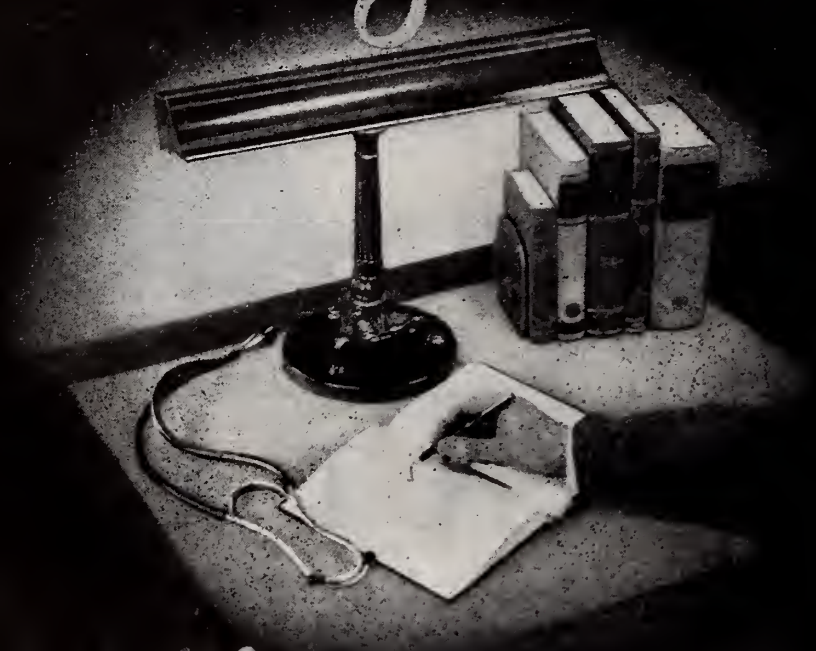

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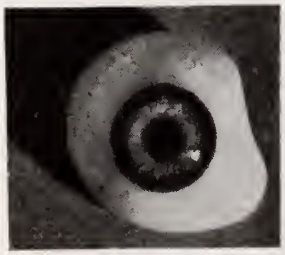

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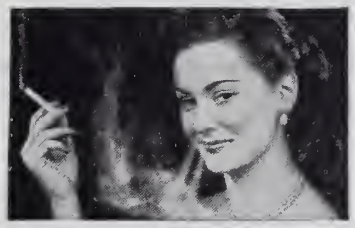

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* *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N.Y. State Journ. Med.*, *Vol.* 35, 6-1-25, *No.* 11, 590-592; *Laryngoscope, Feb.* 1935, *Vol. XLV, No.* 2, 149-154; *Laryngoscope, Jan.* 1937, *Vol. XLVII, No.* 1, 58-60

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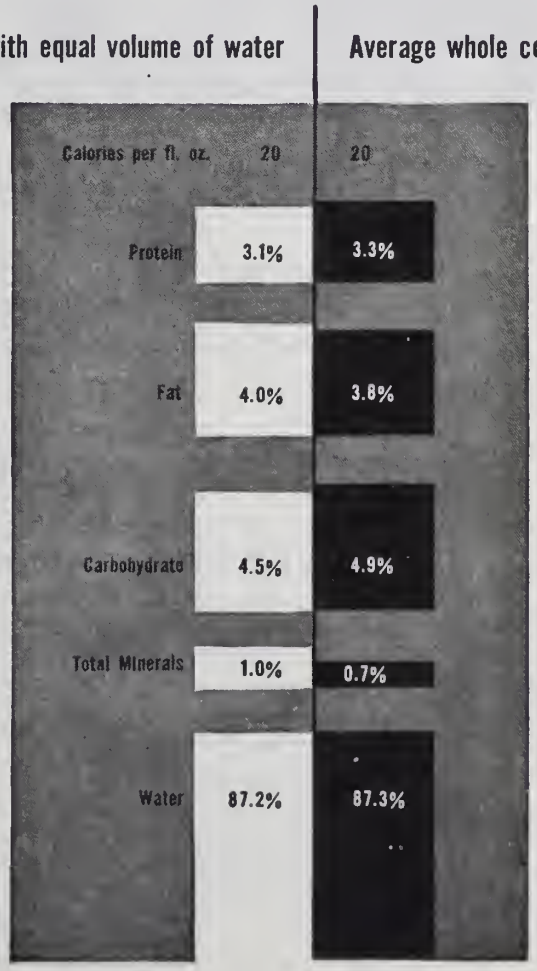

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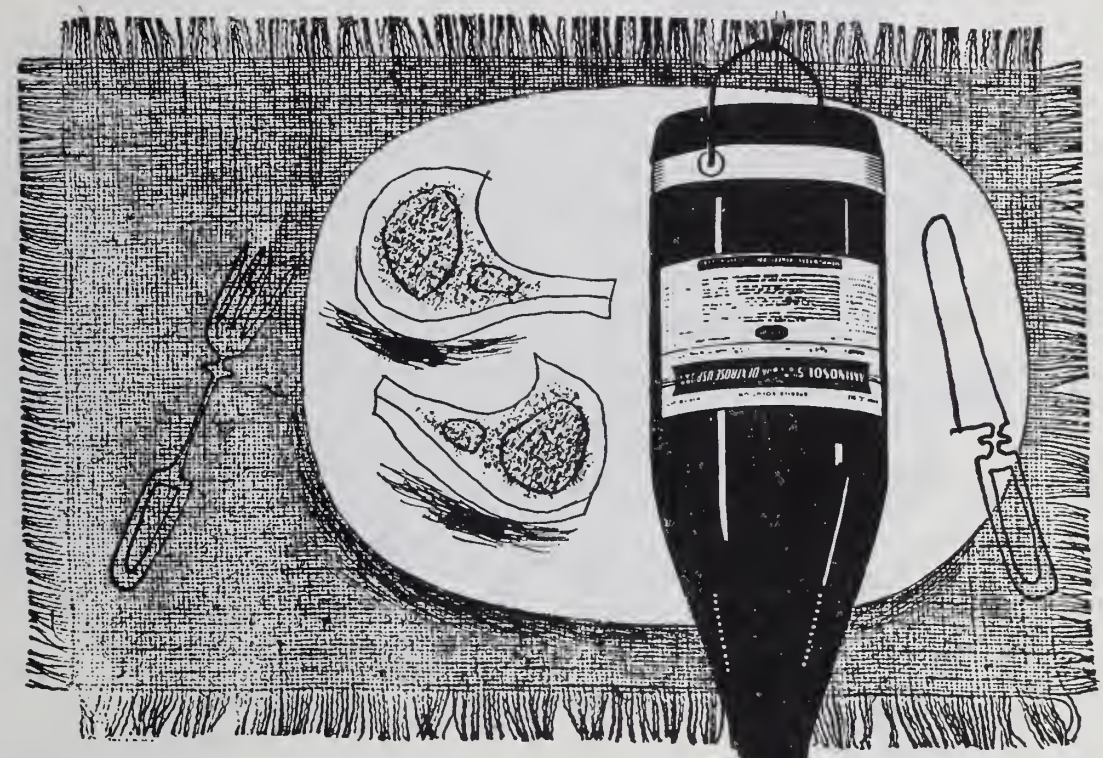

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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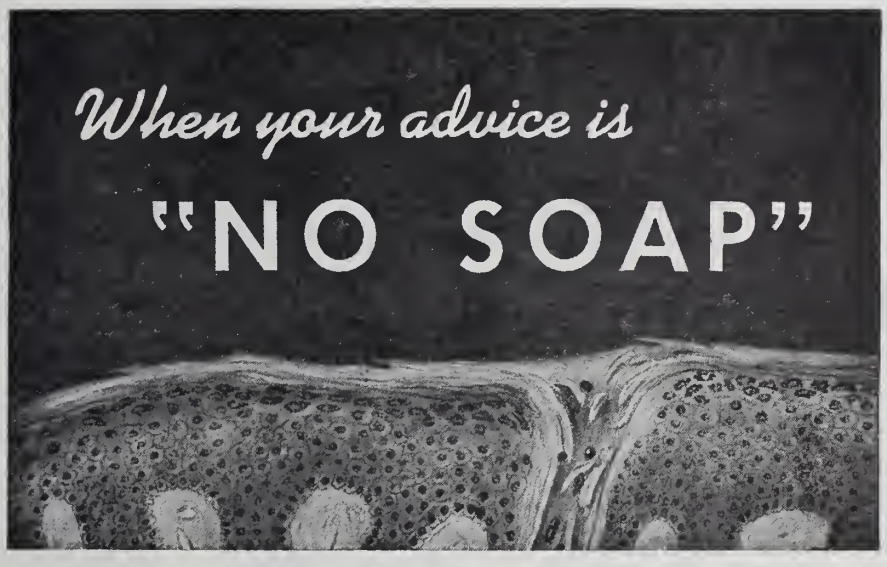

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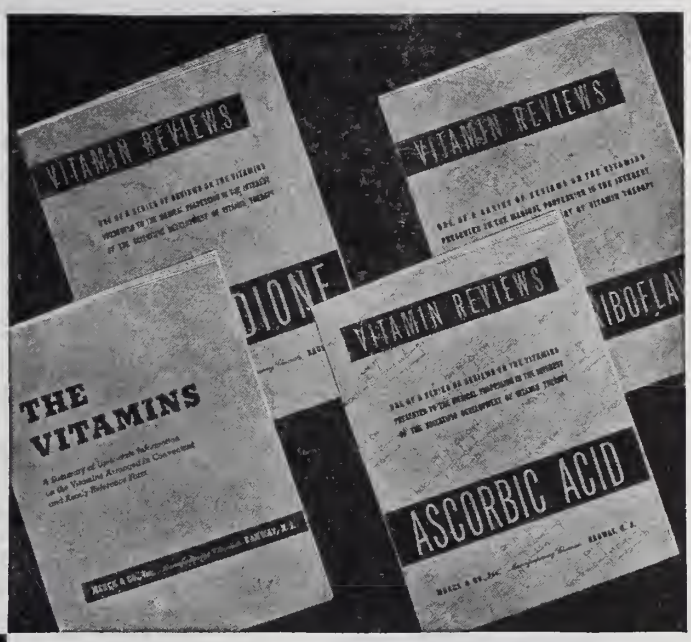

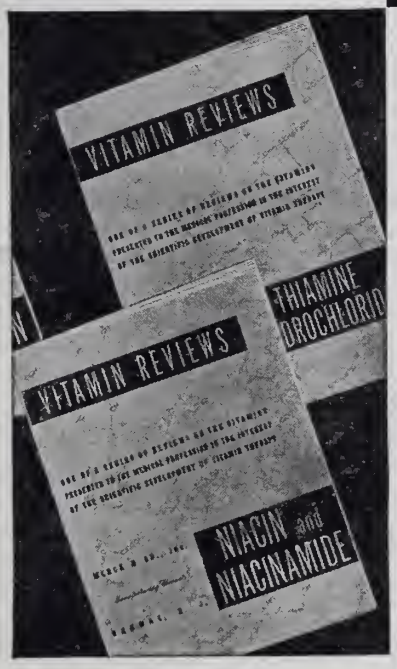

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NEW JERSEY'S HEALTH AND MEDICAL CARE PLAN

No major statement of policy issued by a state medical society in recent years has received more prominent notice or as favorable a reception as has been accorded The Medical Society of New Jersey's twelve proposals for a national health and medical care program published on January 30 by our President, Dr. James F. Norton.

The text of this statement, as authorized by our Board of Trustees, appeared on page 74 in the February Journal.

This declaration is notable in several respects. First, it is almost unique among the various "platforms" and "programs" set forth in recent years by the American Medical Association and some of its constituent units, in that it avoids the mere enunciation of broad principles. On the contrary, each of these twelve points sets forth a specific recommendation designed to meet a particular aspect of the problem of providing good medical care for everyone.

A second notable characteristic is the fact that this plan probably goes further in acknowledging the fact that *government has a role* in solving this problem than has yet been conceded by any official medical group. But in making this acknowledgment, the "New Jersey Plan" precisely defines the necessary functions of government, and, as the *New York Herald-Tribune* observed, it certainly "gives no overweening role to the federal government". As a matter of fact, the total role suggested for the federal government under the "New Jersey Plan" is considerably less extensive than that proposed in any of the major legislative bills

now pending in Congress — including even such measures as the "Taft Bill" or the "Hill Bill", both of which have been sympathetically received by the A.M.A.

Our program places the cart behind the horse. It emphasizes that "voluntary cooperative effort should have priority at all times", and that "government should seek to promote and supplement the efforts of free citizens". Essentially, these proposals, in our opinion, demonstrate that very little new legislation is needed, at the federal level, to enable a satisfactory national health program to be achieved.

Such legislation as may be needed, (and is implicit in these proposals) would place government, at all levels, in the position of furnishing subsidiary aid—for the sake of certain groups of people for whose basic subsistence government has an undeniable—and loudly proclaimed—responsibility.

By "subsidiary" aid, we mean aid that *is subsidiary,* and we refer to the strict dictionary sense of "subsidiary", as "auxiliary, supplementary, one who assists". Certainly in invoking this principle, we make no concession whatever to the idea of government control, dictation or monopoly in the field of medical service.

Here, indeed, is a pattern for teamwork between free citizens and their government—a pattern within which individual initiative, personal freedom and scientific progress will be amply safeguarded. We may be prejudiced, but it seems to us that this practical, specific, down-to-earth program could be a fresh breeze sweeping through the stale verbal fog that obscures so much talk on this subject. You will, we predict, hear a lot more about the New Jersey Plan.

THE SEMANTICS OF CANCER

In a *Treasury of Great Reporting,* Rebecca West speaks of a fascist pamphlet in these striking terms: "It was as if a man walked in with his clothes held open to show a cancer". This may be great reporting but to a cancer patient and his family, it is like being struck with a whip. The word "cancer" has become the rubber stamp which unimaginative writers use in lieu of thinking up a more descriptive term. While it does save wear and tear on the writer's brain, it's cruel reading for cancer patients.

A random sampling of a few newspapers shows the following examples of this cliche:

"Douglas told the Senate that the country's slums were a moral cancer."

"Marquand confesses that this fails to assuage the cancer of an inferiority complex."

"The Attorney General said that this cancer in the body politic should not be covered up."

"Advocating expulsion of communists from the C.I.O., Reuther said that the body politic has a cancer and that we have to save either the body or the cancer."

"Our divorce laws aggravate an already cancerous condition in our society and morals."

"The Far East is so riddled by the malignancy of poverty and ignorance as to. . . ."

"Heavy sentences in the gambling cases will combat this cancerous condition in New Jersey."

"Europe cannot preserve its civilization with this cancer at its edge."

"The cancer of discrimination is a threat to the American ideal."

"The current tendency to defame public officials is a dangerously growing cancer."

Here then are ten samples, selected from newspapers within a few weeks. Do you think it took a fine comb to go through the papers and make these selections? No. A patient who had had a cancer removed picked the phrases out without half trying. To him, the word "cancer" leaps out of the printed page

and hits him in the eye—and in the heart, too. With commendable courage, he has persuaded himself that cancer is not necessarily malignant, that it can be cured and that in his case, it has been cured. Must he continue to see the word flaunted daily as a symbol of hopeless malignancy?

We can do better than that. The word is a stereotype. It lacks freshness. It is overworked and inaccurate. And there are too many cancer patients in this country to permit us to sting them with this simile.

The writers who wallow in this hackneyed comparison do not intend to be cruel. They do not know what they are doing to the patient, and we must therefore forgive them. But someone must call attention to the caustic effect of their carelessly chosen cliche. They must be reminded that it is agonizingly jarring to every cancer patient and to all his loved ones. Since no one seems to have said it before, let it be said now: the word "cancer" must no longer be used as a synonym for everything nasty, malignant or corrupt. It can be a word of hope if only the writers will return it to the dictionary and use some less trite and less tormenting a term. This is surely the least they can do on behalf of one of the most gallant of our fellow-citizens—the courageous cancer patient.

GOVERNOR DRISCOLL ENDORSES N. J. PLAN

In a telegram addressed to Dr. James F. Norton, President of our Medical Society and Vice-President of the American Medical Association, Governor Driscoll, said, "It is appropriate that the historic Medical Society of New Jersey, which traditionally has been a leader in the care of the sick and injured, should offer the State and nation a constructive, stimulating, twelve-point 'cooperative health program'. I am confident," the Governor said, "that your program will prove helpful to those in authority sincerely interested in finding the best possible solution to problems outlined in the statement issued by the Society on January 30."

"For our part," Dr. Norton declared, "we appreciate the Governor's support of our program. We heartily agree with Governor Driscoll's statement, in his second inaugural address, that 'through the medium of State and local cooperation, in close association with the medical profession and the encouragement of private medical and surgical plans, we can make adequate medical care available to all of our citizens'.

"This we profoundly believe and endorse," Dr. Norton said, "and the Medical Society will do its best, in cooperation with official and voluntary groups to fulfill all the objectives of our health program."

Dr. Norton stressed that the New Jersey Plan has been endorsed by national and state legislators of both major parties, and that it has been introduced into the *Congressional Record* with a joint endorsement by Senators Smith and Hendrickson of New Jersey.

ORIGINAL ARTICLES

PRESENT ASPECTS OF MELANOMAS *

Samuel Goldberg, M.D., West Orange, N. J.

Cells in benign and malignant pigmented neoplasms contain melanogenase which may be converted into melanin by 3-4 dioxyphenylallanine. This is known as the "dopa reaction". Nonpigmented melanomas also contain melanogenase but lack certain enzymes so that they cannot be converted into melanin by the "dopa reaction". The origin of melanomas is thought to be neurogenic or epidermogenic and to arise from certain pigmented moles. Their growth is influenced by hormones, since they rarely become malignant before puberty even when their histologic appearance suggests malignancy.

These pigmented tumors are often incorrectly diagnosed. When removing even the most innocently appearing mole, it should always be sectioned and examined by a competent pathologist.

Melanoblasts are extremely radioresistant hence radiotherapy is contraindicated. Electrocoagulation and carbondioxide snow do not destroy all the cells, but rather stimulate some of them. The only treatment that offers a possible cure is adequate surgery.

In benign and malignant pigmented neoplasms the morphology of the cells varies; a single tumor may exhibit round or spindle shaped cells. Even giant cells are frequently encountered. Some contain melanin while others do not.

In some cases the original tumor is pigmented while the metastases are nonpigmented. In other cases the primary tumor is amelanotic while the secondary growths are highly pigmented.

According to Masson, human melanin appears as a granular material varying from dark brown to light yellow. It is destroyed by strong oxidizing agents such as chromic acid, nascent chlorine or hydrogen peroxide. Melanin granules reduce ammonium silver nitrate to metallic silver and become very black. Under normal conditions melanin is always present in the form of cytoplasmic inclusions. In melanomas it is set free in the blood plasma and excreted in the urine. The cells producing melanin are *melanoblasts*. The cells containing pigment without having produced it are *melanophores* or chromatophores.

Masson concludes as follows: The "dopa-positive" melanoblast is the only melanin producing cell. The concept that the melanoblast secretes melanin and excretes it into other cells gives it the function of a glandular cytocrine in contradistinction to an exocrine or endocrine. When cancer cells invade the epidermis, the melanoblasts inject them with pigment. They may even migrate from the epidermis into the intradermal neoplastic strands, load them as well as the tumor stroma with pigment. Thus mobility is another potential property of the melanoblast.

Greenstein washed melanoma tissue in the centrifuge with dilute acetic acid and then dried it. The yield of jet-black material was 9.7 per cent of the protein. On analysis it yielded 11 per cent nitrogen, 2.5 per cent sulfur, 1.4 per cent cystine-cysteine, 8.9 per cent methionine, 1.9 per cent tyrosine, and 1.3 per cent tryptophane. A considerable enrichment in sulfur is thus achieved in the melanin pigment by the enzymatic degradation of the protein, and it would appear that at the point or points of attachment of the pigment to the protein there is a relatively high proportion of the sulfur-containing amino acids. The melanin pigment so isolated by pancreatic digestion of the melanotic pseudoglobulin may be provisionally designated as a polypeptide to which a third to a half of the weight of pigment is attached.

Amelanotic melanoma cells do not exhibit tyrosinase, "dopa" oxidase, or p-phenylenediamine oxidase activity. Such cells may possess particulate anlage similar to those postulated in melanoblasts but pigment granules are not produced owing either to the lack of enzymes or to the complete inhibition of those essential oxidases that might nevertheless still be present.

DuShane first presented the neural crest hypothesis i. e., the migration of pigment cells from the neural crest to the epidermis. This is established in the lower vertebrates. In mammals, results are not conclusive.

Mayer questioned whether heavily pigmented

* From the Department of Pathology, Presbyterian Hospital, Newark, N. J. Read by invitation, April 25, 1949, to the Annual Meeting, The Medical Society of New Jersey.

cells can still divide. He finds it difficult to account for the multiplication of cells in fast growing melanomas while mitoses are so very scarce.

Laidlaw thought that pigmented moles are remains of the reptilian tactile spot and the mammalian tactile hair follicle. It is a link from the pigment tactile organs of the reptilian type to hairy tactile organs of the mammalian type. Vascular nevi are analogous to the most primitive amphibia which have no lungs but have richly vascularized skins serving as cutaneous lungs.

Allen classifies pigmented nevi as follows:

1. Junctional nevus (dermoepidermal nevus or marginal nevus).
2. Intradermal nevus (common mole or neuronevus).
3. Blue nevus (Jadassohn-Tieche nevus).
4. Compound nevus.
5. Juvenile melanoma.

He believes that the junctional nevus is derived from true epidermal cells and that cutaneous malignant melanomas arise from junctional nevi; hence they are epidermogenic. When the common mole (intradermal nevus) is associated with a melanocarcinoma it may be assumed to have grown from the underlying epidermal or junctional element of the compound nevus. The blue nevus and the mongolian spot are, Allen thinks, neurogenic. Because nevi of the scrotum and of the palmar and plantar aspects of the extremities may be assumed to be junctional nevi, he believes that it would be wise to remove them prophylactically, preferably prior to puberty.

Pack, who adheres to the neurogenic concept, states that the melanoma is the most malignant and dangerous of all accessible cancers. The great majority of them are preventable through early and appropriate treatment of the precursory lesion, the common pigmented mole. These tumors commonly possess the property of withdrawing tyrosin from the blood stream and elaborating the complex chemical which is converted into the visible pigment through the activities of enzymes in the cytoplasm of the melanoma cell. Occasionally the melanoma cells may be so actively reproductive that the formation of pigment does not occur and the tumor may appear to be nonpigmented. The converting enzyme, however, is present in the cytoplasm and can be recognized by the dioxyphenylalanine or dopa reaction.

Pigmented nevi and melanomas occur relatively more frequently in blonde individuals or those who freckle easily and do not tan well on exposure to sunlight.

Pigmented nevi are not commonly found on the feet and genitals but the proportion of melanomas in these locations is relatively high. In other parts of the body they occur with equal frequencies. The feet and the genitalia are more subject to repeated irritation hence tumors in these areas are more likely to undergo malignant change than the same tumors in other parts of the body.

The influence of hormonal stimulation is evidenced by the fact that nevi are invisible at birth and then show pigment after birth on exposure to light. Many are not visible until after the onset of puberty. At this time, pigmented nevi become more numerous, more darkly pigmented, and tend to become elevated. Some nevi in infants and children even if they show malignant characteristics histologically, may not behave as such until after puberty. This class of tumors should be termed as prepubertal melanoma. The malignant melanoma in its derivation from the pigmented nevus is closely related to the endocrine system and markedly influenced by the activity of the endocrines notably the gonads, the suprarenal cortex and perhaps the *pars intermedia* of the pituitary body. Malignant melanomas often occur in adolescent girls and boys just after the onset of puberty when they grow rapidly and become widely disseminated. A malignant melanoma developing from a pigmented nevus during pregnancy grows very rapidly and so widely disseminates that it becomes inoperable.

It does not seem possible that a single injury to normal skin can induce a growth as highly complicated as a neuronevus or a malignant melanoma. Repeated chronic irritation of pre-existing moles could be a factor in inducing their change into a malignant variety. This is particularly true when moles are found on regions subjected to frequent and constant pressure, such as on the neck, the arms, the

groin, the feet, and the genitals. When a pigmented mole that has long been quiescent undergoes certain changes, such as becoming elevated, with increased pigmentation, or with ulceration, bleeding, and localized discomfort or pain, it may indicate that the tumor is becoming malignant.

TREATMENT

The doctrine that a pigmented mole should not be removed unless it bothers the individual is a most dangerous thesis. When a pigmented mole begins to bother the patient it may mean that a melanoma has already developed. The physician may excise what he believes to be a benign mole in a conservative fashion in the office without a microscopic study of the specimen only to have the patient later return with evidence of regional or distant metastases. When a pigmented mole is removed during its benign state it never recurs. Local recurrence or distant metastases after removal indicates that the original tumor was alrealy malignant at the time of excision. These tumors are extremely radio-resistant hence x-ray or radium therapy is contraindicated. Electrodesication is too superficial and not wide enough to remove all of the neval cells. If a part of the tumor remains the irritation of this procedure may induce it to grow more rapidly and even to metastasize. Wide surgical excision is the only means to combat this neoplasm. In the Memorial Hospital the ratio of "five year survival" for malignant melanoma without metastases is 18 per cent while with metastases and treated by radical surgery the survival rate is 15 per cent.

CASES

Case 1. A newborn female, of white parents, showed widespread pigmented nevi covering the shoulders, neck, and chest anteriorly and posteriorly resembling a short jacket or cape. On the chin she had a triangular shaped area. There were also various spots scattered over the rest of the body. At eight years of age the dark areas show an enlarged surface corresponding to the growth of the body. The anterior portion of her neck shows evidence of plastic surgery done for the cosmetic effect.

Case 2. White female, 15 years of age, showing extensive pigmentation of the skin as well as a rare example of "bathing trunk" type pigmentation. This differs from the small number of similar cases described previously in the literature in that this girl did not show an excessive growth of hair in the pigmented areas. Aside from the abnormal pigmentation, the patient showed nothing unusual. At the age of twenty-two she gave birth to a normal infant free from pigmentation.

Case 3. A woman fifty years of age had a hemorrhoidectomy which histologically showed an extremely vascular papillary growth covered by stratified squamous epithelium. In the submucous tissue, there were groups of nevus cells in places composed of spindle-shaped cells, polyhedral cells, and in areas they were of a peritheliomatous arrangement. Many of the cells exhibited various phases of mitosis. The scant amount of melanin was in the surrounding interstitial tissue and in cells with eccentric nuclei suggestive of plasma cells. As a result of the diagnosis of an actively growing melanoma, an inguinal node was removed several days later. The metastatic tumor in this node was much more pigmented than the original tumor. It was also extremely vascular.

Case 4. In a right femoral hernia sac, removed from a female 23 years of age there was a nodule which histologically was diagnosed as nonpigmented melanoma. After this diagnosis the surgeon recalled snipping off a pigmented spot on her right leg four months previously.

Case 5. White female, 63 years of age, had an ulcerating black mole on the lower outer side of the right thigh. Removal by diathermy was followed by a swelling of the right inguinal lymph nodes. Intensive x-ray treatments were given over the inguinal region and the site of the original tumor. This was followed, very shortly, by the appearance of fast-growing, rapidly spreading, moderately hard, blackish-blue subcutaneous nodules.

The time from the removal of the original tumor to the appearance of these nodules was approximately twenty-one months. Physical examination showed a markedly emaciated female appearing chronically ill. There were numerous tender elevations beneath the skin in various parts of the body. Some of these were ulcerating. The liver was palpable two centimeters below the costal margin. Aside from this, no other abnormalities were noted. Laboratory examinations revealed a moderate hypochromic anemia, otherwise nothing relevant. X-ray of the lungs showed numerous small areas of increased density, undoubtedly metastases. Skeletal metastases were not seen.

The patient died two years after the removal of the original tumor. Autopsy showed an extremely cachectic female, with numerous subcutaneous nodes over the entire body, including the head, shoulders, chest, back, upper and lower extremities, varying from 1 to 6 centimeters in diameter. Some were bluish-red in color, others were pale. The right breast contained three nodules, each a centimeter in diameter, next to the pectoralis fascia. The left breast showed one nodule posterior to the nipple. The lungs were crepitant. Both lungs contained scattered nodules varying from 1 to 15 millimeters in diameter, more numerous in the right lower lobe. The myocardium of

the right atrium contained a nodule about 5 millimeters in diameter. Aside from this, the heart showed nothing remarkable.

The stomach contained a small nodule in the wall of the lesser curvature. The mucosa of the jejunum contained a cone-shaped nodule from which whitish, cord-like lymph vessels extended into the mesentery as far as the enlarged nodular firm mesenteric nodes which drained this area. The liver was pale, and contained a nodule 2 centimeters in diameter near the notch of the vena cava. The gall bladder contained six nodules bulging into the lumen.

The spleen was studded with nodules bulging on the surface. The left renal cortex and the perirenal fat contained five nodules, some pigmented, others free from pigment.

The subcutaneous nodules were composed of large cells with large nuclei, some of which were polymorphous. These cells are arranged around vascular spaces in a peritheliomatoid arrangement.

The nodules in the lungs contained central necrosis. The jejunum showed, in addition to the metastatic melanoma in the mucosa, areas of ulceration with neutrophilic infiltration. The liver showed extensive fatty metamorphosis in addition to the neoplastic nodule. The gall bladder showed neoplastic cells in nodular formation in the mucosa and the muscular coat. The nodule in the gastric wall differed from the other nodules. It was composed of smooth muscle fibers running in all directions, characteristic of a leiomyoma.

This is a case of melanomatosis originating in a "mole" of the right thigh with widspread subcutaneous, pulmonary, cardiac, hepatic, cholecystic, splenic, mesenteric, and renal metastases. Of especial interest are metastases into the mucosae of the jejunum and gall bladder.

Case 6. A 49 year old white man was admitted to the hospital with a history of "asthma" of ten years' duration with dyspnea on exertion, wheezing, and a slight cough. There was a red fluctuating swelling in the right axilla. Incision over the fluctuating area revealed no free pus. The gland was soft and degenerated. The patient was treated with sulfadiazine and the wound healed.

Four months later, he was readmitted with a marked enlargement of the axillary nodes. Biopsy showed two minute nodules in the skin composed of spindle-shaped cells free from pigment. The underlying tissue showed granulomatous cellulitis.

The axillary mass increased in size until it measured 12 centimeters in diameter. The overlying skin was bluish in color. The axillary mass was excised, and the center contained a softened area 5 centimeters in diameter. Microscopic examination showed extensive necrosis with neutrophilic and eosinophilic infiltration and areas of large cells with large eccentric nuclei free from pigment, many containing phagocytized neutrophiles.

On either side of the right nipple, there were two pigmented moles. These were composed of large cells containing a considerable amount of melanin, many showing mitotic figures.

Five months later, the patient was readmitted with a low grade fever. X-ray showed a dense shadow in the left upper lobe on the medial side, interpreted as being tuberculous. The tuberculin patch test was positive. The sputum did not show any acid-fast organisms. The x-ray also revealed a small round area of density suggestive of a growth. He had a number of dark nodules on the skin in the scarred area over the right chest. A dark pedunculated nodule was removed for study. It contained large, endothelial type cells in sheets interspersed with capillaries and a scant stroma. Some of these cells contained melanin arranged in spots, while the rest were free from pigment.

The patient died fifteen months after the first admission. Autopsy showed an extremely cachectic male, exhibiting a large number of pigmented, raised nodules covering an area of the skin extending from the right axillary fold to the sternum and from the clavicular area to the umbilicus. There was an osteoma on the median side of the right tibia just beneath the knee joint. The left pleural cavity contained about two liters of clear brownish liquid. The parietal pleurae on both sides were covered by pigmented nodules. In addition there were large areas of melanosis in the parietal pleurae.

The left lung contained a large metastatic mass attached to the chest wall. The left upper lobe and the upper part of the left lower lobe were firm. The left lung generally was studded with small nodules. On section, there was a slightly pigmented nodule, in the upper lobe. In the right lung, there were two soft, yellowish nodules. The tracheobronchial lymph nodes were swollen and dark. Some of the mesenteric nodes were calcified. The small pigmented nodules of the lung were composed of old fibrovascular tissue containing proliferated bronchioles. The larger, pale nodules were made up of large cells, mostly perivascular. The cells had a peritheliomatoid arrangement, and many of them contained polymorphous nuclei. One small area in the renal medulla showed a papillary adenoma.

This was a case of a melanoma originating in a pigmented mole on the skin of the right chest with epidermal, axillary, pleuritic, and pulmonary metastases. The first indication of illness was evidenced by massive suppurative cellulitis and right axillary lymphadenopathy. Of particular interest are the large nonpigmented cells with eccentric nuclei in the axillary nodes, many showing phagocytized neutrophiles.

Case 7. A 54 year old white man was admitted for a hemorrhoidectomy. Just before he was put under the anesthetic he asked the surgeon to remove a small brownish mole on his neck. This mole was diagnosed as an actively growing melanoma in spite of its benign gross appearance. He was discharged from the hospital after four days and readmitted four months later with hematuria. Cystoscopic examination revealed "hemorrhagic papillomata" of the bladder. Two weeks later he developed a cough and the chest x-ray was suggestive of silicosis. Since the patient was a knife-grinder by occupation this seemed reasonable.

Two weeks later he died. Autopsy revealed a metastatic melanoma of the lungs, pleura, medias-

tinal lymph nodes, myocardium, epicardium, liver and tracheo-bronchial nodes. The liver weighed 3000 grams and was studded with black nodules varying from 2 to 20 millimeters in diameter. The mucosa of the stomach contained minute pigmented spots. The mesentery of the small intestines contained nodules similar to those found in the liver, pancreas, kidneys, and adrenals. The lining of the urinary bladder contained melanomatous areas. The skeletal muscle and sternum contained similar lesions.

Histologically these tumors were composed of melanocytes with the cytoplasm containing pigment granules.

He had bilateral hydrothorax with the pleural fluid being bark brown in color.

This was a case of a malignant pigmented nevus of the skin of the neck with generalized metastases.

DISCUSSION

Cases 1 and 2 presented extensive pigmentation of the skin of various parts of the body including areas that are usually considered subject to constant irritation. Patient number 2 passed through puberty and a pregnancy without any noticeable change. These should be termed *melanosis*.

Cases 3 and 4 are malignant *melanomata* that metastasized to the inguinal region. One originated in a "hemorrhoid", the other was primarily on the skin of the leg with metastasis in a nodule along the wall of a femoral hernia sac. The original tumor was not sectioned.

Case 5 is a malignant melanoma on the thigh, diagnosed as a hemangioma, which was followed by generalized metastases. Some of the metastatic nodules were pigmented while others were free from melanin.

Case 6 is a mélanoma of the skin of the chest with axillary and pulmonary metastases. An unusual feature of this case is the presence of large cells free from pigment some of which contain phagocytized neutrophiles.

Case 7 is that of a small, raised, innocently appearing melanoma of the skin of the neck which soon after its removal was followed by general hematogenous metastases.

These cases emphasize the necessity of examining histologically every pigmented nevus removed no matter how innocent it may appear.

The idea that a pigmented nevus is benign and becomes malignant on removal is not borne out by these cases. It is possible that these tumors were malignant and had begun to spread before removal. Of course, crushing the tumor during surgical removal might facilitate its recurrence.

Macklin cites cases of hereditary melanomas particularly of the choroid.

Judging by the extreme variation of their behavior clinically and histologically it does not seem possible that all melanomata originate from a single cellular structure. It seems more likely that they originate from a variety of cellular anlage. While nonpigmented melanomata contain more mitoses, many of the highly pigmented tumors grow as rapidly (and sometimes more rapidly) than the nonpigmented tumors.

SUMMARY

Seven cases are presented. Two are benign pigmented nevi of unusual distribution. Of the five malignant melanomata the distribution of the primary site was as follows: Two on the leg, one a "hemorrhoid"; one on the neck and one on the chest. From the complex histologic structure of these neoplasms it seems possible that the histogenesis is from a variety of cells rather than from a single cellular anlage.

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TREATMENT OF ARTHRITIS WITH "ANATHION" *

LEON LIBENSON, Ph.D., Flemington, N. J., and
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In 1936 one of the writers proposed the use of tetrathiodiglycollic acid for the treatment of arthritis. The experimental results obtained on 36 patients, including cases of rheumatoid arthritis, osteo-arthritis and fibrositis, have been highly encouraging and were reported in a note[1] published in 1937 after experiments carried out over a period of nine months. For practical purposes and for extensive use, tetrathiodiglycollic acid presents the inconvenience of irritating and sometimes painful effects particularly when leakage takes place into the soft tissues during injection. This has been overcome by the preparation of a stable enough solution of sodium tetrathiodiglycollate, the pH of which approximates that of the blood pH.

This treatment has been followed up in this country for over a period of ten months in which the sodium salt of the tetrathiodiglycollic acid was used instead of the free acid. Although the number of cases treated during this time is not large, we deem it appropriate to report the results obtained thus far because they substantiate the early claims about the value of the treatment. Advanced cases of rheumatoid arthritis in which other forms of treatment failed have shown remissions or remarkable improvement, leading us to believe that this treatment will prove to be a step further in the control of rheumatic diseases.

RATIONALE

The basis on which this treatment is founded concerns the mode of action of the gold salts on the one hand and elemental sulfur on the other.

In an article on toxicity and mode of action of the gold salts, one of us (L.L.) reported[2] that when glutathione or cysteine is treated with gold salts (either ionic or in the form of gold-sulfur compounds) their sulfhydryl groups are blockaded and no longer give the characteristic reaction with sodium nitroprusside, the usual reagent of the SH radical. The reaction taking place can be represented as follows:

$$G—SH + AuX = G—SAu + HX$$

where G represents the non-sulfhydryl residue of glutathione or cysteine and X represents the non-gold residue of the gold compound.

The gold mercaptide thus formed (G—SAu), when in the presence of an excess of sulfhydryl-compound, in aqueous solution, generates hydrogen sulfide which can be detected with specific reagents. The chemical reactions taking place in this process can be expressed by the following equations:

$$G—SH + AuX = G—SAu + HX$$
$$G—SAu + H_2O = G—OH + AuSH$$
$$AuSH + G—SH = H_2S + G—SAu$$

Through this process, a continuous destruction of SH compounds will take place in the tissues when gold salts are administered parenterally and will last as long as gold remains in the system. The fact itself that gold and other SH blockading elements such as arsenic, mercury, et cetera, are strongly retained in the tissues, can be explained as being the results of the immediate fixation of the element by the SH compounds present in the tissues as soon as by metabolic process the metal sulfide (AuSH) is formed. The toxic reactions encountered in the treatment of arthritis with gold salts would be the result of this destruction of sulfhydryl compounds in the cells which prevents or disrupts the process of oxidation-reduction. The continuous process of blockading SH compounds in the tissues also accounts for the delayed toxic effects long after treatment with gold salts has been discontinued and is why the incidence of toxic reactions has no definite relation to the acute toxicity of the different gold salts originally used. In effect, any gold compound with either high or low acute toxicity, reacting with SH groups, will be transformed in the system into the com-

* "Anathion" is the name of sodium tetrathiodiglycollate, the ampuls of which are prepared at Crescent Laboratories, Trenton, New Jersey. "Anathion" is not yet commercially available but will be marketed soon.

1. Ruiz, Moreno A., and Libenson L.: *Boletin del Centro Antirreumatico*. University of Buenos Aires, 1:185 (1937)
2. Libenson, L.: *Experimental Medicine and Surgery*, 3:46 (1945).

plex mercaptides of the SH compounds present in the tissues, and the effect of destroying more SH compounds and thus producing the toxic manifestations will be exerted through the action of these mercaptides as such, regardless of the original form in which gold was combined when administered.

Concerning the therapeutic mode of action Sabin and Warren[3] found that while exerting a curative effect on mouse arthritis, the gold salts have no bacteriostatic action on the arthritis - producing pleuropneumonia - like bacteria and that cultures of these bacteria in media containing gold salts not only grow satisfactorily but also maintain their ability to produce arthritis in mice. This shows clearly that the gold salts exert their therapeutic effects not by directly destroying the arthritis-producing agent but through the reaction of the tissues acted upon by the gold compounds. It was pointed out[2] that "the immediate fixation of the gold salts by the sulfhydryl compounds and the formation of hydrogen sulfide by the action of the formed complex mercaptides on an excess of SH compounds would indicate the possibility that the specific therapeutic action might be exerted not directly by gold but by the hydrogen sulfide generated in the tissues subsequent to the injection of the gold salts."

It should be pointed out on the other hand that the heavy metals such as gold, besides blockading SH groups also have a catalytic effect on the oxidation of reduced glutathione into the oxidized form by the action of molecular oxygen and "it is upon this behaviour that the functional importance of glutathione appears to depend".[4] This oxidation takes place according to the following equation:

$$2\ \text{G—SH} + \text{O} \xrightarrow{\text{Au}} \text{G—S-S—G} + \text{H}_2\text{O}$$

Thus the therapeutic effects of the gold salts can be attributed either to the formation of hydrogen sulfide at the tissue level or to the increase in the production of oxidized forms of glutathione (G—S-S—G) or -S-S- containing enzymes and proteins.

The observation[5] that most patients with rheumatoid arthritis are affected with sulfur deficiency in hair and nails and that improvement is coincidental with the increase of cystine in nails would indicate that the formation of -S-S- compounds in the tissues plays an important role in the therapeutic mechanism of action. In the clinical experiments carried out on arthritic patients we have used a water soluble compound very rich in sulfur (Anathion*), which releases in aqueous solution elemental sulfur and has been found to react with sulfhydryl compounds present in the tissues the way gold salts do in producing hydrogen sulfide on one hand and oxidized form of glutathione on the other. This compound is sodium tetrathiodiglycollate: $NaOOC\text{-}CH_2\text{-}S\text{-}S\text{-}S\text{-}S\text{-}CH_2\text{-}COONa$, which contains 52 per cent of total sulfur, half of which is released by hydrolysis as molecular sulfur (S_2) according to the following equation:

$$\text{NaOOC-CH}_2\text{-S-S-S-S-CH}_2\text{-COONa} = \text{NaOOC-CH}_2\text{-S-S-CH}_2\text{-COONa} + \text{S}_2$$

The molecular sulfur (S_2) thus released reacts with sulfhydryl compounds with the formation of H_2S and -S-S- compounds:

$$4\ \text{G—SH} + \text{S}_2 = 2\ \text{G—S-S—G} + 2\ \text{H}_2\text{S}$$

where G represents the non-sulfhydryl residue of glutathione.

When sodium tetrathiodiglycollate is injected intravenously before its decomposition takes place, which occurs within about one hour after being dissolved, the release of molecular sulfur will take place at the tissue level and will react with sulfhydryl compounds probably within the cells. Unlike gold, however, which blockades irreversibly the SH groups and thereby destroys sulfhydryl compounds in the tissues, the sulfur released by sodium tetrathiodiglycollate does *not* destroy glutathione or other SH compounds. By the action of sulfur these SH compounds are only transformed into its disulfide (oxidized) form: G—S-S-G, which in turn can be reversibly transformed in the system by a reduction process back into its reduced form:

$$\text{G—S-S—G} + \text{H}_2 \rightleftharpoons 2\ \text{G—SH}$$

By this behaviour sodium tetrathiodiglycol-

3. Sabin, A. B., and Warren, J.: *Journal of Bacteriology*, 40:823 (1940).
4. Baldwin, E.: *Dynamic Aspects of Biochemistry*. Cambridge Univ. Press. London (1948) p. 233.
5. Sullivan, M. X.: *American Journal of Surgery*, 42:620 (1939).

late, accomplishes both actions of producing hydrogen sulfide and -S-S- compounds at the tissue level as gold salts do without destroying essential sulfhydryl compounds in the cells. This mode of action explains the low toxicity of sodium tetrathiodiglycollate, the minimum lethal dose of this compound when determined on mice being 100 milligrams per kilogram.

Unlike colloidal sulfur, (the particles of which are variable in size depending upon its age and method of preparation) the elemental sulfur released by sodium tetrathiodiglycollate is molecular sulfur (S_2) which is absorbed as such by the tissues without producing anaphilactoid shock characteristic of the colloidal dispersions.

Being unstable in aqueous solution, sodium tetrathiodiglycollate is prepared immediately before injection by mixing dry tetrathiodiglycollic acid with an aqueous buffer solution of dibasic sodium phosphate, the amount of the acid and phosphate being such that the resultant solution has a pH approximating that of the human blood.

EXPERIMENTAL

Thirty-four patients were treated with intravenous injections of 10 milligrams of Anathion* administered every other day. Before beginning treatment complete blood counts and sedimentation rates were determined on most patients. During the period of treatment no other medication was administered.

None of the patients showed any toxic manifestations during and following treatment including patients receiving over 60 injections.

Results have been evaluated by the objective and subjective symptoms including swelling, pain, degree of mobility of the joints and the general condition of the patients.

Most of the patients showed signs of improvement after receiving 10 to 15 injections. Some patients, however, (particularly those in an advanced stage of the disease) showed no evidence of relief until after receiving 30 to 35 injections following which remarkable improvement was observed. On the other hand some patients with rheumatoid arthritis and particularly those affected with fibrositis showed improvement after receiving but 5 to 8 injections.

Following is a detailed report of four typical cases of severe rheumatoid arthritis:

CASE 1

A woman, age 36, suffered from rheumatoid arthritis for the past 6½ years. She was the first patient treated with Anathion* in this series. She was a typical example of advanced rheumatoid arthritis; her hands, elbows, shoulders, knees and feet being markedly involved, her elbow joints practically ankylosed at 90 degrees flexion. She was sure that no treatment would improve her condition, since from its inception she had submitted to many different therapeutic efforts including a treatment for over a year with gold, none of which had contributed any noticeable benefit but actually, as she stated, "made me worse". The first eight injections brought no apparent relief in either pain or swelling of the affected joints. She was still unable to arise from bed unassisted, dress herself or raise a cup to her lips because of stiffness and pain and lack of grasping ability. The ninth dose of Anathion* seemed to initiate the reduction in the stiffness and swelling. From the ninth injection until the 24th, relief was steady and remarkable. Her entire attitude concerning the impossibility of cure changed and she was able to convince a second sufferer to try this treatment. Injections continued at the rate of three a week. She was now able to do her household duties and, in addition, to work in her garden several hours a day. She occasionally complained of muscle pain particularly after extending herself in her work.

To date after receiving 64 injections her sedimentation rate was retaken and showed a reduction from 27 to 16 millimeters (Cutler). Her joints are now completely free from pain and swelling. She sleeps well, eats and dresses herself normally and performs activities she says she has not been able to do in years. In addition, she gained six pounds in weight. She now can grasp with normal pressure; her hands and feet are apparently "cured". She continues to exhibit reduced extension and contraction of the forearms upon the arms due to the right-angled posture she maintained during the painful periods previous to this treatment; but exercises at home, even without adequate and proper medical supervision, have given her at least 15 per cent more mobility. We feel that her reversal is most dramatic and the patient concurs stating she feels she is a "completely different person".

CASE 2

A woman, 47 years of age, had been suffering with rheumatoid arthritis for seven years. It began in her knees but three months later her hands became involved and soon thereafter a generalized arthritis of her feet, elbows, shoulders and wrists was present. She tried various forms of treatment, each for periods of less than six months, but she gradually became worse. At the beginning of treatment with Anathion,* sedimentation rate was 29 millimeters (Cutler) with a vertical curve; the affected joints were markedly reduced in motion and

greatly swollen. Ambulation was extremely difficult because of knee involvement. During the period of her first 25 injections, no noticeable relief was observed except occasional subsidence of pain. She finally considered it too difficult to come to the office and therefore had to be treated at her home. Four weeks after treatment at home she gradually and steadily became improved. The intense swelling of knees subsided, her hands, elbows and shoulders became normal. She is now completely free of pain and is able to return to her household duties after receiving 55 injections. Her present sedimentation rate is 25 millimeters. The curve of sedimentation, however, is diagonal instead of the vertical curve observed before treatment.

CASE 3

A 19-year old woman suffered with rheumatoid arthritis for 18 months. She exhibited marked swelling of her ankle joints and tenderness and pain were present in both wrists, elbows and knees. She had gold salts treatment for six months during which time she became worse and had to cease work. Her sedimentation rate was 33 millimeters; hemoglobin was 50 per cent. The red cell count was 3,720,000 and the leucocyte tally was 10,200. There was moderate polynucleosis. She received Anathion* three times a week, plus a copper-iron preparation for the control of her marked hypochromic anemia. At present, after 41 injections, mobility of the joints is greatly improved, and she is completely free of pain or swelling. The blood picture has also changed and is now: 7150 leucocytes; 3 540,000 red cells; hemoglobin 60 per cent, sedimentation rate 28 with a diagonal curve instead of the previous vertical curve. She is still under treatment, but feels well enough to have resumed work.

CASE 4

A woman age 53, had early rheumatic symptoms in adolescence. For the past six years she has suffered continuously with generalized rheumatoid arthritis. During the last three years she has been treated with many different therapeutic agents including salicylates, hormones, vitamins and physiotherapy. Treatment with gold compounds over a period of one year afforded relief but was discontinued because of toxic effects. She had to give up work. At the beginning of treatment with Anathion* she had continuous pain and generalized swelling and could walk only with great difficulty. After getting 15 injections she was completely free from pain and the mobility of the joints became practically normal. She still had some limitation of flexion-extension of the ankle joints. At present, after 38 injections, she is completely free of rheumatic symptoms. The residual stiffness in the ankle joints has disappeared. She resumed work and is able to drive her car. Her sedimentation rate at present is 15 millimeters.

In the following table, the clinical results obtained in the treatment of 21 other cases of rheumatoid arthritis, 4 cases of osteo-arthritis, and 5 cases of fibrositis are shown:

Patient	Age	Sex	Occupation	Diagnosis	Duration of Disease	Sed. Rate Before Treatment (Cutler) Millimeters	Number of Injections	Present Sed. Rate Millimeters	Clinical Results
1.	46	F	Housewife	Rheumatoid Arthritis	16 years	33	40	13	Great Improvement
2.	42	M	Laborer	Rheumatoid Arthritis	4 years	28	25	12	Excellent
3.	47	F	Housewife	Rheumatoid Arthritis	10 years	20	55	18	Great Improvement
4.	54	F	Housewife	Rheumatoid Arthritis	2 years	10	14	10	Excellent
5.	24	F	Housewife	Rheumatoid Arthritis	6 years	16	38	4	Great Improvement
6.	62	M	Retired	Rheumatoid Arthritis	15 years	..	21	..	Slight Improvement
7.	40	F	Nurse	Rheumatoid Arthritis	1 year	..	10	.	Great Improvement
8.	48	M	Truck driver	Rheumatoid Arthritis	5 years	..	10	..	Great Improvement
9.	34	M	Electrician	Rheumatoid Arthritis	3 years	18	22	.	Excellent
10.	62	F	Housewife	Rheumatoid Arthritis	3 years	26	50	..	Great Improvement
11.	44	M	Cook	Rheumatoid Arthritis with history rheum. fever	11 years	13	17	..	Great Improvement
12.	40	F	Housewife	Rheumatoid Arthritis	3 years		21	.	Great Improvement
13.	47	F	Housewife	Rheumatoid Arthritis	2 years	..	14		Great Improvement

Patient	Age	Sex	Occupation	Diagnosis	Duration of Disease	Sed. Rate Before Treatment (Cutler) Millimeters	Number of Injections	Present Sed. Rate Millimeters	Clinical Results
14.	48	F	Housewife	Rheumatoid Arthritis	2 years	..	8	..	Great Improvement
15.	45	F	Housewife	Rheumatoid Arthritis	2 years	..	8	..	Great Improvement
16.	50	F	Waitress	Rheumatoid Arthritis	6 years	..	15	..	Great Improvement
17.	45	F	Machine operator	Rheumatoid Arthritis	2 years	..	8	..	Moderate Improvement
18.	54	M	Guard	Rheumatoid Arthritis	11 years	25	22	..	Slight improve. ceased treatment
19.	36	F	Housewife	Rheumatoid Arthritis	2 months	16	10	..	Moderate Improvement
20.	41	F	Housewife	Rheumatoid Arthritis	10 months	10	10	..	Great Improvement
21.	28	F	Housewife	Rheumatoid Arthritis	1 year	24	15	..	Great Improvement
22.	75	F	Housewife	Osteo Arthritis	12 years	..	43	..	Slight Improvement
23.	80	F	Housewife	Osteo Arthritis	3 years	..	46	..	Great Improvement
24.	59	F	Housewife	Osteo Arthritis	15 years	..	11	..	Slight Improvement
25.	59	M	Foreman	Osteo Arthritis	13 years	..	14	..	Great Improvement
26.	38	M	Railroad Office Worker	Fibrositis	6 months	..	28	..	Excellent
27.	35	F	Housewife	Fibrositis	2 months	12	9	..	Excellent
28.	44	F	Housewife	Fibrositis	8 months	13	5	..	Excellent
29.	35	M	Laborer	Lumbo-sacral Fibrositis	3 months	..	12	..	Moderate Improvement
30.	35	M	Laborer	Lumbo-sacral Fibrositis	6 months	..	12	..	Moderate Improvement

At present a large number of patients showing great improvement follow the same pattern of reduction in symptoms as those who are now in total remission after a more prolonged treatment. The patients are being closely followed-up to determine the length of the remission periods and the course of their sedimentation rates after treatment has been discontinued.

SUMMARY AND CONCLUSIONS

1. A new therapeutic agent, sodium tetrathiodiglycollate has been used in the treatment of 25 cases of rheumatoid arthritis, 4 cases of osteo-arthritis and 5 cases of fibrositis.

2. This treatment is based on the property of sodium tetrathiodiglycollate to release sulfur at the tissue level when injected intravenously in aqueous solution. The element thus released reacts with the SH compounds present in the tissues much as gold salts do, but without destroying these SH compounds and without producing any toxic effects. Unlike colloidal sulfur (the particles of which are relatively large and variable in size) the element released by sodium tetrathiodiglycollate is molecular sulfur (S_2) which acts as such at the tissue level without producing any anaphilactoid shock characteristic of the colloidal dispersions.

3. The clinical results show that sodium tetrathiodiglycollate is a highly effective therapeutic agent for the treatment of rheumatic diseases, particularly rheumatoid arthritis and fibrositis.

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THE MUSCLE PAINS OF ASTHMA

Samuel Gordon, M.D., Paterson, N. J.

In the usual case of asthma there are generally no complications. After the attack is over, the patient returns completely to a normal state. However, puzzling sequelae may unnecessarily complicate the case; and for these, other diagnoses may be made. I have reference to pains in various parts of the abdomen, thorax, lumbar area and over the neck. In the moderately severe and severe asthma patient, there is considerable muscular exertion involving the muscles and accessory muscles of respiration. After a bout of asthma, the patient is not unlike the athlete who has run a ten mile race. The "next-day feeling" in one's muscles is familiar to all who have ever exerted themselves physically. These muscle pains can be localized and can imitate other conditions for which even surgery might unnecessarily be done. This is particularly true in simulated appendicitis. Less urgent post-asthma symptoms resembling neuritis, pleurisy, arthritis, or renal colic may also supervene. Following are a few cases out of many illustrating this point:

1. A thin undernourished 52 year old male, a chronic intermittent asthmatic of twelve years' duration was hospitalized in 1940 for status asthmasticus. The only complaint was that of asthma and its attendant exhaustion which had existed for one week. With the usual medication, the patient was improved by the third day so that asthma was present only in the evening. However, during the day, he complained of severe pain in the right lower quadrant. Physical examination of abdomen revealed tenderness and spasticity in this area. White cell count was 12,500. Temperature was 100. The considerable dehydration of patient could account for the borderline count as well as the temperature. Heat applied to area gave a good deal of relief. During the night when the asthma returned, the patient did *not* complain of right lower quadrant pain although palpation still showed tenderness. The next day pain returned. Except for the pain, the patient seemed a good deal better generally. A similar series of events occurred the following night. The temperature and leucocyte counts remained normal thereafter, but the pain persisted during the asthma-free periods. At the end of a week the right lower quadrant pain all but disappeared and he was discharged with normal blood findings. He has never had appendiceal pains since.

2. A 16 year old boy had an allergic history including perennial asthma. The appendix had been removed earlier. He was brought to a surgical clinic in 1941 with right lower quadrant pain. A Meckel's diverticulum or "adhesions", was the tentative diagnosis. History revealed moderate severe asthma attacks for two to three weeks which had subsided just before arrival. All laboratory findings were normal. He had pain and tenderness in the right lower quadrant with some pain in the epigastrium. He was held for observation without medication for five days. The symptoms disappeared. On further questioning, he remembered similar but less severe abdominal pain after previous asthma attacks. In fact appendectomy had then been advised.

3. A 45 year old woman had a history of "chronic asthma". The current episode started ten days ago. She was hospitalized for one week. The asthma improved considerably after five days. Right lower quadrant pains developed with considerable muscle spasticity. Blood count normal. Five cubic centimeters of 2 per cent novocain were injected into the painful area with immediate disappearance of pain. Deep palpation produced no pain. Subsequent history was uneventful except for later asthmatic attacks. A second episode of asthma was treated at home satisfactorily when pain developed across right posterior chest at level of the rhomboid muscles simulating intercostal neuralgia. Pain was intense for one day and diminished with application of heat.

4. A 24 year old sthenic man who never had asthma, was subject to hay fever every August. The present attack was acute and sudden following outdoor activity as a surveyor during the ragweed season. After three days of severe asthma and hay fever, symptoms subsided and epigastric pain developed. There was no gastric disturbance. Pain was constant for 48 hours unrelated to food. Heat and analgesics controlled the pain satisfactorily.

5. This was an acute episode in an old asthmatic. During defervesence of asthma, the patient complained of severe pain in left chest. This pain was related to inspiration. A cardiac origin was at first suspected. Because of the diffuse nature of pain, the lack of fever and the subsequently normal x-rays, it was concluded that this was strain of intercostal muscles rather than pleurisy.

6. This 32 year old male was hospitalized twice for right lower back pain, thought to be ureteral colic. Two cystoscopic examinations and intravenous urographies were negative. He never passed stones or blood in urine. He had had "breathing difficulty" at that time but this was ignored. He was referred to me for frank bronchial asthma in May 1949. Right lumbar spasticity was noted and the area was injected with 2 per cent novocain. This effected immediate temporary relief of pain.

The ultimate proof of the origin of these pains could of course be made only by pathologic examination. However, the appearance of the patient, the character of the pain and the follow-up history indicate beyond reasonable doubt that these phenomena are entirely muscular. In case 2, appendectomy had already been performed, possibly unnecessarily. In case 4, novocain was superficially injected into muscle with relief of pain. In case 6, a genito-urinary study was negative.

In the other cases the pains are so obviously muscular that the patient complained of generalized muscular "soreness". It is to be noted that the acme of the pains usually is reached during the defervescence of the asthma, or 24 to 48 hours after.

CONCLUSION

Cases are presented to demonstrate the simple sequelae of muscle pain in moderately severe and severe asthma which, in special cases, may be a source of unnecessary worry to the doctor particularly by suggesting appendicitis or renal disease.

540 Park Avenue

CALLING L. I. C. M. ALUMNI

Alumni Association of Long Island College of Medicine announces Alumni Day on Saturday, April 29. The morning will be devoted to a series of practical scientific sessions, and the social highlight of the occasion will be the Annual Dinner at 7 p. m. at the Columbus Club in Brooklyn. For further information and a detailed program, write Alumni Association, L. I. College of Medicine, 350 Henry Street, Brooklyn 2, N. Y.

GRADUATE LECTURES IN BERGEN COUNTY

The Bergen County Medical Society together with Rutgers University announce a series of graduate lectures to be held at the nurses' auditorium of the hospital in Englewood (350 Engle Street). All lectures begin at 4:30 p. m. Tuesdays and each session lasts 1½ hours. Any member of The Medical Society of New Jersey is welcome to attend. The fee is $10 which covers any and all lectures. Checks should be sent to Dr. John E. McWhorter, 151 East Palisades Avenue, Englewood, N. J. The schedule follows:

March 7—Carbohydrate Metabolism
March 14—Protein Metabolism
March 21—Fat Metabolism
March 28—Renal Function
April 4—Cardiovascular Emergencies
April 11—Gynecology in General Practice
April 18—Psychosomatics and the Menopause
April 25—Therapeutic Nerve Block

AMPUTEE CONFERENCE

Notice is given of the fourth annual Amputee Conference to be held on April 20, 21 and 22 at the Kessler Institute for Rehabilitation, Pleasant Valley Way (near Northfield Avenue) West Orange. This is one of the major rehabilitation and orthopedic events of the year, and interested physicians may obtain a detailed program by writing to: Director of Professional Education, Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J.

OTOGENIC AND TUBERCULOUS MENINGITIS

A PROBLEM IN DIFFERENTIAL DIAGNOSIS

Bela Steiner, M.D., Budapest, Hungary, and Joseph Lang, M.D.,
Perth Amboy, N. J.*

Before the use of streptomycin, a child with tuberculous meningitis was so certainly destined to die, that early diagnosis was only a matter of academic interest. Today, the early recognition of the tuberculous character of such a meningitis may be literally a matter of life and death. And it is not an easy disease to recognize. It may be swift or slow in onset; the patient may have a normal temperature, or a high fever. The child may have been exposed to tuberculosis; or such a history may be lacking. Since streptomycin offers the best chance of recovery, a child should be hospitalized as soon as the diagnosis is suspected; as soon, indeed, as the possibility of tuberculous meningitis is even entertained. If it later turns out that the diagnosis was erroneous, the streptomycin may be discontinued without danger.

One critical diagnostic problem does remain however. If the patient had an otogenic abscess, he may die during his streptomycin therapy, whereas surgery might have saved his life. Conversely, an operation for abscess on a child who actually had tuberculous meningitis, may also be fatal.

The traditional diagnostic criteria of tuberculous meningitis are the low spinal fluid sugar and the finding of the tubercle bacillus. But low sugar level only points to meningitis *in general;* it does not denote its tuberculous origin. In about half of all cases of tuberculous meningitis, tubercle bacilli are found in the spinal fluid within 48 hours. But that leaves us still with 50 per cent of the cases undiagnosable by this criterion.

The following case offers a characteristic diagnostic problem:

A 9 months old infant was admitted to the hospital, having suffered from "influenza" for two weeks. Symptoms were anorexia, restlessness (especially at night) vomiting and coughing. She had no fever. Frequently she would pull at her ear. B.C.G. vaccination had been given previously.

Examination revealed tense fontanelles with slight neck rigidity. Two convulsions occurred on the day of admission. Spinal fluid pressure was increased. Twenty-four hours later, the following remarks were made: although the infant has healthy parents, the possibility of a tuberculous infection should be thought of, because the maternal aunt has tuberculosis. The Mantoux test (1 to 10,000 dilution) is negative. Cerebral spinal fluid is colorless; protein is 100 milligrams per 100 cubic centimeters. We find 75 cells per cubic millimeter; most of them are lymphocytes. The spinal fluid also shows fibrin clot formation.

Chest films show (in both middle zones) small irregular dense masses and a few thick strands. At both bases, there is an irregular density of small nodular and straight shadows about the size of a penny. The otologist believed that he was dealing with otogenic meningitis because of a history of previous otitis media, which had been followed by signs of a meningitis in the presence of a negative tuberculin reaction. He interpreted the x-ray findings as indicating early bronchial pneumonia. He believed that it was a favorable omen that in the spinal fluid, only lymphocytes were seen, and that the cell count was not high. Knowing that a fibrin clot might appear in the spinal fluid in any form of meningitis, he performed an operation.

Peri-antrally, he found a pea-sized abscess; the dura was infected. Two weeks after operation, the infant died. At autopsy, tuberculous meningitis was found, as well as a generalized miliary tuberculosis. A walnut-sized caseous necrotic focus was noted in the right lung. The child had also had paraverterbral bronchopneumonia.

In connection with this case, the following questions should be asked:

1. Was the diagnosis of otogenic meningitis logical?

2. Was it possible to diagnose tuberculous meningitis within the first twenty-four hours?

3. Would this have explained all the signs and symptoms present at that time?

4. Is it possible that both purulent and tuberculous infection, in combination, were responsible for the disease?

There were many facts supporting the otolo-

* This paper was written by Dr. Steiner who is assistant professor of pediatrics at the University of Budapest and was translated and edited by Dr. Lang.

gist's opinion. The negative Mantoux reaction led him to discard a tuberculous etiology. After excluding tuberculosis, he accepted the prevalent otologic theory, viz: if symptoms of meningitis appear in connection with otitis media, then the meningitis is either a sequel to the otitis, or both developed simultaneously.

Otology textbooks underemphasize the possibility that luetic or tuberculous meningitis may simulate otogenic abscess. Many clinical signs were inconsistent with tuberculous meningitis in this case. Symptoms of tuberculous meningitis develop slowly, fever is not high, and delirium convulsions appear later. The otologist saw the infant the day before the operation, and thought that otitis media developed simultaneously. The otologist was more influenced by the convulsion than by the fact that the infant did not have fever. The normal temperature would have been rare in otogenic meningitis; but it is only natural for an otologist who finds signs of otitis and meningitis, to assume a causal connection.

It is incorrect to rely on one negative Mantoux (1 to 10,000) to exclude definitely the possibility of tuberculous infection. With this dilution, the tuberculous reaction is positive in only half of the cases. During the first few days, when the differential diagnosis between otogenic and tuberculous meningitis is urgent, a 1 to 1000 dilution should be used immediately.

Although I know that injection of a concentrated tuberculin solution might cause troublesome local or dangerous general reaction, I fear that postponement of an operation might also be dangerous, and might more seriously threaten the life of the patient.

Even with the low concentrated tuberculin solution, we cannot exclude the tuberculous infection with absolute surety. Positive tuberculin does not prove that the meningitis is tuberculous. On the other hand, in negative tuberculin reaction, meningeal tuberculosis is possible. If a stronger tuberculin solution had been used a positive reaction would probably have resulted in more carefully weighing the possibility of tuberculous meningitis. Even with negative reaction a pediatrician would not have excluded tuberculous meningitis.

The infant was sick for a week before the appearance of otitis. Symptoms were not severe; the mother did not take her to the doctor. Anorexia, restlessness, and coughing made it look like "influenza". The mother could not believe that the feverless infant was seriously sick. Yet this seemingly mild infection caused otitis media and meningitis, without fever. The convulsions did not exclude tuberculous meningitis because with this disease, onset with convulsions in small infants is not very rare. Here we are dealing with a well-developed infant who should have reacted to a purulent infection with fever; yet the leukocyte count was only 12,000 and in the differential smear, the neutrophile leukocytes amount to only 65 per cent. This slight leukocytosis is more frequent in tuberculous than in purulent infection.

The spinal fluid was colorless and clear; characteristic of tuberculous meningitis. However, in the early stages of purulent meningitis, the fluid is also clear. The fact that only lymphocytes were present could be interpreted as suggestive of early purulent meningitis; but it should be suspicious that a fibrin clot formed in the spinal fluid. Even this is not pathognomonic of tuberculous meningitis because this may be present whenever the permeability of the brain covering is increased. There is, however, one important differential point: the fibrin clot in purulent meningitis is usually thick and the cells are leukocytes. In purulent meningitis, the thin spider-weblike clot is never found. There are two lines of reasoning: (1) In incipient purulent meningitis, only leukocytes will be found in the sediment; (2) In an advanced stage of tuberculous meningitis, there will be a fibrin clot, meaning a marked increase in permeability. One of these hypotheses must be incorrect. We have to reject the first possibility, and conclude that the fibrin clot with typical lymphocytosis is characteristic of tuberculous meningitis.

Does tuberculous meningitis explain all the symptoms? The meningitis did not begin with the paracentesis. The anorexia and vomiting had already been caused by meningitis. If that is true, the x-ray should be reinterpreted, especially in an afebrile infant whose chest was

negative to percussion and auscultation. The processes in both lower lobes should be interpreted as tuberculosis, and not as influenzal bronchopneumonia. The otitis media could be tuberculous or suppurative. We would consider one of these combinations:

(1) Tuberculous meningitis and otitis.
(2) Tuberculous meningitis with nontuberculous otitis.
(3) Tuberculous meningitis with purulent meningitis plus purulent otitis.

If the patient has tuberculous meningitis, streptomycin is the treatment of choice; while in purulent meningitis caused by purulent otitis, operation plus penicillin is indicated. The clinical picture here was explained by tuberculous meningitis. Perhaps on the last day there was otogenic purulent meningitis added to a pre-existing tuberculous meningitis. We cannot deny that possibility.

Relative lymphocytosis in the spinal fluid does not exclude the possibility of concomitant purulent infection. If there is simultaneous infection with tubercle bacilli and with pyogenic cocci, the "tuberculous" character of the spinal fluid is likely to remain unchanged.

Except for the convulsion, this baby did not present any "serious" symptom. There was little febrile or leukocyte reaction. The spinal fluid was free of pus cells and remained sterile. Certainly the surgical interference was unhelpful. As indicated, a careful analysis of the history, spinal fluid and physical findings could have led to the correct diagnosis.

111 Market Street, Perth Amboy

AVULSION OF THE DISTAL BICEPS BRACHII TENDON *

Raphael R. Goldenberg, M.D., Paterson, N. J.

A review of the available literature since 1898 [1] indicates that approximately eighty per cent of the seventy-seven reported cases [2] of traumatic avulsion of the distal biceps brachii tendon have been surgically treated by the replacement of the avulsed tendon to the bicipital tuberosity.

The two cases to be presented illustrate the clinical and operative findings, the operative technic employed, and the results obtained.

CASE ONE

A man, aged 32, sustained an injury to his right elbow when he tripped and fell striking the lower third of his right forearm against a machine. He felt a sharp tearing pain in the right elbow region and was unable to actively move the elbow. Five days later, the right upper extremity was held close to the chest wall, maintaining the elbow in 90 degrees of flexion. The proximal half of the volar aspect of the forearm was discolored. At the elbow joint active extension was possible to only 115 degrees and active flexion to 75 degrees. Active supination was impossible whereas active pronation was complete. Any attempt to increase passively the range of either elbow or forearm motions was accompanied by a sharp increase of pain in the elbow region. A palpable gap was present in the antecubital space and tenderness was marked in this region. The normal resistance of the biceps tendon was absent. On active flexion of the elbow joint, the belly of the biceps brachii muscle was deviated to the medial aspect of the arm, and was displaced one and one-half inches higher than that on the left side.

Operative Findings: Operation was performed eight days after the injury. The lacertus fibrosus was found lacerated. The antecubital space was filled with clotted blood. The distal biceps brachii tendon was located in the lower third of the medial aspect of the arm. The tendon end was bulbous, slightly discolored and some clotted blood was found between the tendon fibers. A thin frayed fringe of tendon tissue was found on the posteromedial aspect of the radial tuberosity.

CASE TWO

(Courtesy Dr. N. Dingman)

A man, aged 52, sustained an injury to his right upper extremity when he attempted to disengage the bumper of his car. As the car moved the patient felt a snapping sensation in the right elbow

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* From St. Joseph Hospital, Paterson, N. J. Read by invitation, to the New Jersey Orthopaedic Society, October 9, 1948.

1. Acquavive, M.: Marseille Medicale, 1:570 (1898).
2. Dobbie, R. P.: American Journal of Surgery, 51:622 (March 1941); also Hook, F. R., and Mazet, R.: United States Naval Medical Bulletin, 40:409 (April 1942); also, Milch, H.: Bulletin of the Hospital for Joint Diseases, New York, 9:14 (April 1948).

region. Three weeks after the injury the right elbow region presented slight swelling and tenderness. The biceps brachii tendon was not palpable. There was a definite gap in the antecubital space. Active motion was possible through the following range: extension to 135 degrees, flexion to 70 degrees, supination was impossible and pronation was complete. Any attempt to passively increase this range of elbow or forearm motion was resisted and painful. On active flexion of the elbow joint the belly of the biceps brachii muscle was deviated to the medial aspect of the arm, and was pulled one inch higher than on the left side.

Operative Findings: Operation was performed twenty-four days after the injury. The lacertus fibrosus was intact. The bulbous tip of the distal biceps brachii tendon was found in the lower third on the medial aspect of the arm. A few frayed tags of tendon tissue were found on the postero-medial aspect of the radial tuberosity.

Operation: Although an excellent functional result was obtained in Case One, a post-operative keloid developed because the midline longitudinal incision cut across the transverse flexion creases in the antecubital space. Therefore in Case Two the "Z" incision advocated by Bunnell[3] was employed. The transverse superficial veins were ligated and cut. The cephalic vein was retracted laterally. The space between the biceps brachii and the brachioradialis muscles was widened and the radial nerve identified. The bulbous portion of the distal tendon end of the biceps brachii muscle was reduced in size, leaving a smooth conical stump. The tendon was securely transfixed by a Bunnell tendon suture of chromic catgut. The musculocutaneous nerve was then identified on the anterior surface of the brachialis muscle. On the antero-medial aspect of the brachialis muscle the brachial vein and artery together with the median nerve were identified and retracted medially. The interval between the pronator teres and the brachioradialis muscles was widened. The recurrent radial artery and vein were ligated and cut. The radial tuberosity was then exposed. With the elbow flexed to 90 degrees and the forearm completely supinated, a drill hole was placed through the anterior cortex of the radial tuberosity. A second drill hole was made through the cortex, one-half inch to the ulnar aspect of the first drill hole in the radial tuberosity. The anterior drill hole was enlarged sufficiently to admit the tendon. By means of an aneurysm needle the tendon was passed through both drill holes, the suture pulled taut, and securely fixed to the biceps tendon. The wound was closed in layers.

Post-operative Course: The extremity was immobilized in plaster extending from the proximal third of the arm to the distal palmar crease, with the elbow in 90 degrees of flexion and the forearm in complete supination. Finger and shoulder motions were instituted early. The plaster was removed after three weeks. Complete motion and power were restored after three months.

SUMMARY

1. Two cases of avulsion of the distal biceps brachii tendon are reported.
2. The clinical and operative findings are presented.
3. The operative technic of replacement of the avulsed tendon to the radial tuberosity is described.
4. Complete motion and power were restored after three months.

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SEMINAR ON EYE, EAR, NOSE AND THROAT

The New York Polyclinic Medical School and Hospital will hold a five-day seminar on otolaryngology and ophthalmology during the five-day period beginning April 17, 1950. Some of the leading surgeons in these specialties are listed as guest speakers. To obtain a detailed program write to the Medical Executive Officer, New York Polyclinic Medical School and Hospital, 351 West 50th St., New York 19, N. Y.

3. Bunnell, Sterling: *Surgery of the Hand.* Lippincott, Philadelphia (1944).

IMPORTANT DIAGNOSTIC ERRORS IN DIABETES †

Benjamin Saslow, M.D.,* Newark, N. J.

Diabetes often gives rise to atypical, unexpected or bizarre symptoms and signs. In addition, the generally accepted laboratory criteria for its detection may be absent when clinically expected and present in unrelated conditions or even in healthy individuals.

This paper is a consideration of certain important aspects of the confusion in the diagnosis of diabetes and an attempt at its clarification.

URINE AND BLOOD EXAMINATIONS IN DIAGNOSIS

The value of a proper routine urine examination on every patient cannot be overemphasized. Omission (or a careless test) may result not only in diabetes being completely overlooked but often delays proper treatment until some dramatic event like coma, first heralds its presence.

Too often uncritical evaluation of laboratory findings result in severe and typical diabetic symptoms being interpreted as due to "nervousness", "need of a vacation", or the psychoneurosis of the menopause.

This creates an unfavorable impression of the attending physician and the medical profession especially by those who have been successfully indoctrinated with the prime imporance of a routine physical examination in detecting disease in its incipiency.

An illustrative case report follows:

1. Female, aged 48, with frequent hot flashes and aberrations in menstruation. She complained of weakness, depression, exhaustion and a desire to sleep after meals. A urinalysis *upon arising* was completely negative. A complete somatic physical examination was unrevealing. The "menopause" was indicated as the source of her trouble and large amounts of estrogens by all routes were given without effect.

She was referred to a psychiatrist and an abstract of his report follows: "She fails to find gratification for subjective needs under certain circumstances and her ego which probably was stunted during her childhood or possibly in adolescence, limits her constitutional endowment to meet the stresses and strains of her glandular adjustments during the period of the menopause. She is in definite depression and electric shock therapy is strongly indicated and recommended."

She was advised that six treatments would be of great help and probably cure her. After receiving five without effect, she became discouraged and returned to her family physician for further advice. In error (sic) she brought a urine specimen passed *one hour after luncheon* instead of the recommended "first one upon arising". This was loaded with sugar. Her fasting blood sugar was 230 milligrams per cent and another taken two hours after a heavy carbohydrate breakfast was 362.

Her symptoms, hyperglycemia and psychiatric troubles cleared up promptly and completely with dietary adjustment and protamine zinc insulin.

Glycosuria and hyperglycemia may be absent at one time and present at another. It is found most frequently one or two hours after a planned (or even casual) heavy carbohydrate meal rather than in the traditional and time-honored "first specimen of urine" and samples of blood in the morning.

However, if hyperglycemia happens to be discovered in a fasting blood sugar, that is another matter and is conclusive evidence that diabetes is present particularly if glycosuria, diabetic symptoms and an hereditary taint are found.

As a convenient modification of the usual laboratory tests when diabetes is suspected, the physician should examine casual urine and blood specimens collecting during his afternoon or evening office hours, one to two hours after the patient's luncheon or dinner.

It might seem surprising that so simple a procedure as testing the urine for sugar should be considered important enough to warrant consideration but most errors begin at this point.

The busy practitioner frequently performs this test by adding five to ten drops of urine to an indifferent amount of Benedict's solution in a test tube, waves it quickly over a Bunsen

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† Presented before the Section on Metabolism of The Medical Society of New Jersey in Atlantic City on April 28, 1949.

burner, gives a rapid glance and interprets it as negative if no immediate color change takes place.

It is astonishing how often this test will show a true and positive reduction reaction that otherwise would be missed if the following simple directions are followed.

Add 6 to 8 drops of urine to a teaspoonful of Benedict's solution in a test tube. Mix. Place in a boiling water bath for five minutes. Remove and let cool.

If the test is positive, it is of no practical importance at this point to determine the exact nature of the reducing substance but a blood sugar should be drawn "on the spot". If this lies between 160 to 180 milligrams per cent, a glucose tolerance test should be performed as soon as possible.

Should such a random blood sugar be found to be over 180 milligrams per cent and especially where the diagnosis of diabetes previously had been suspected, further diagnostic blood studies are rarely necessary.

Even if the fasting blood sugar is normal or but slightly elevated, a glucose tolerance test is generally indicated if suggestive symptoms are present or a positive diabetic family history can be elicited.

A physician always has a tube available to obtain blood for a Wassermann test. He should always be prepared with a bottle containing a little oxalate for drawing blood for a blood sugar examination.

If it is inconvenient to have this specimen examined immediately, it may be stored in a refrigerator until the following morning and an addition of 10 per cent to the result will give a useful and reasonably accurate reading. In this connection it seems appropriate to call attention to a new and rapid blood sugar method which has been devised for screening purposes only. It is a simple office procedure and soon will be available for general use. The details may be found in an article recently published by Wilkerson and Heftmann.[1]

An unexpected finding of hyperglycemia without clinical evidence of diabetes should never warrant this diagnosis. Technical errors frequently creep into blood sugar determinations and associated diseases may be contributory.

A high blood sugar may exist with a sugar-free urine and is often discovered purely by chance. I have seen several patients with blood sugars over 300 who simultaneously were aglycosuric.

Actually, bladder urine and venous blood removed at the same time do not represent direct or simultaneous relationships as the rate of urine formation and blood sugar concentration varies constantly and irregularly during and prior to the period of urine formation.[2]

Although diabetic patients often get along well with very high blood sugars, the physician is not justified in ignoring this. It has been my experience that the patient's margin of safety under such circumstances is relatively decreased and they are more liable to coma with less reason than in those whose blood sugars have been maintained at levels that are normal or reasonably above it.

STUMBLING-BLOCKS IN GLUCOSE TOLERANCE TESTS

It is not within the province of this article to compare or evaluate the well known glucose tolerance tests. Those interested in greater detail should consult the excellent paper of Feinberg.[3]

I personally use the one in which an adult is given 75 to 100 Grams of glucose by mouth (a child proportionately less), and where samples of blood and urine are collected simultaneously in the fasting state and every hour for two or three times thereafter. Although such tests yield important diagnostic information, they can change from time to time in the same patient and not infrequently under comparable conditions. Thus, they may appear to be positive when they actually are not; and if no clinical evidence of diabetes is present, a repetition is strongly advised particularly if the findings are borderline.

The patient should not undergo physical exertion before or during the test. Exercise be-

1. Wilkerson, H. L. C., and Heftmann, E.: Journal of Laboratory and Clinical Medicine, 33:236 (1948).
2. Duncan, G. G.: Diseases of Metabolism, 2nd Ed., 1947. W. B. Saunders Company, Philadelphia, p. 691.
3. Feinberg, J. C.: JOURNAL of The Medical Society of New Jersey, 45:486 (1948).

fore glucose may bring about a temporary, immediate hypoglycemia while exercise after glucose ingestion may reduce the expected hyperglycemic level.

The diet for two or three days previously should be a normal one and contain a minimum of about 300 Grams of carbohydrate daily.[4]

Patients should not be permitted to smoke before or during the test as the blood sugar in certain sensitive individuals has been reported to rise as high as 50 per cent above normal because of the nicotine.[5]

Temporary abnormal "curves" may be induced by menstruation, emotional instability and intoxications. Infections and fever will often produce a similar effect.

False positive curves may also be found in hypertension, obesity, hyperthyroidism, acromegaly or after diets restricted in carbohydrate.

NON-DIABETIC STATES PRODUCING MELITURIA

If the glucose tolerance test is normal, then and only then is it of practical importance to determine the nature of the reducing substance in the urine.

Reduction of Benedict's solution can result from pentose, lactose, glucose, gelactose, maltose, and the glycuronates. The details of their specific and individual identifications can be found in any standard clinical laboratory manual. False reactions may result from the use of salicylates, estrogens, morphine, epinephrine, the xanthines, chloroform, ether and curare.

If glucose has been found to be the reducing substance and the tolerance test is normal, the only condition that requires consideration is *renal glycosuria*. If the patient is pregnant, the *temporary glycosuria of pregnancy* must also be suspected. Without adequate investigation, such patients are practically always erroneously diagnosed as cases of mild, borderline or true diabetes.

It is a serious and not uncommon error to treat individuals with such benign metabolic aberrations with insulin, restrictive diets and have them undergo the inconvenience, unpleasant experiences and worry that this needlessly entails.

These should be suspected immediately when no classical diabetic symptoms are present and dietary restrictions alone seem to have no effect on the intensity of the glycosuria. In other words, if the glycosuria is decreased or disappears with only curtailment of the diet, the condition frequently will be found to be true diabetes; if it does not clear up, one of these benign conditions must also be suspected.

a. *Renal glycosuria* is a condition in which the glucose tolerance test is normal and sugar is found rather constantly in the urine. It is innocent, incurable, asymptomatic and requires no treatment. It is "typical" if glycosuria occurs constantly even at hypoglycemic levels. It is "cyclic" if the glycosuria occurs only after heavy carbohydrate meals and under such circumstances is frequently described as "alimentary glycosuria".[6]

At this point it might be added that a rare condition, *chronic pentosuria*, may easily be mistaken for renal glycosuria if the urinary reducing substance is not qualitatively investigated; otherwise it does not differ clinically from renal glycosuria.[7] This condition is due to a poorly understood inbred metabolic disorder, is accompanied by a normal glucose tolerance test, is hereditary, incurable, symptomless and benign.[8]

Transient pentosuria which is unrelated to it may occur from the ingestion of large amounts of prunes, plums, grapes or cherries.

b. *Glycosuria of pregnancy* is a benign and temporary true renal glycosuria occurring in 10 to 15 per cent of normal pregnant women, most commonly in the latter months and in multigravidae. It is due to a temporary and unexplained lowering of the renal threshold for sugar, with a resultant glycosuria that clears up promptly in one or two weeks after delivery. The reducing substance in the urine is true glucose and not lactose as a large number of physicians seem to believe.

If sugar is found in the urine for the first time during a pregnancy devoid of diabetic symtoms, it probably is due to this condition but for final proof, a glucose tolerance test should be done.

In the past year I have seen three pregnant women with benign glycosuria treated as true diabetics with insulin and diet. In one of these, an attempt was made to correct the glycosuria (unsuccessfully of course) by increasing the insulin each day until the patient was rendered

4. Conn, J. W., and Newburgh, L. H.: Journal of Clinical Investigation, 15:665 (1936).
5. Lundberg, T., and Thyselius, R.: Acta medica Scandinavica, Supplement, 38:1 (1931), quoted by A. Marble in Treatment of Diabetes Mellitus, by Elliott P. Joslin *et al.*, 8th Ed., (1946), Lea and Febiger Company, Philadelphia, p. 169.
6. Holst, J. E.: Acta medica Scandinavica, 63:47 (1925-1926).
7. Jones, H. W., and Sussman, W.: American Journal of the Medical Sciences, 173-513 (1927).
8. Marble, A.: American Journal of the Medical Sciences, 183:827 (1932).

unconscious from profound hypoglycemia. Needless to state, all these patients were "cured" after delivery.

Diabetes mellitus may begin during pregnancy and this alone is reason enough for proper and complete investigation if glycosuria is first discovered during this time. Whether true diabetes is discovered before or during pregnancy makes little difference. Such patients require immediate, proper and special obstetrical and metabolic management.

Lactosuria is a very common finding and occurs physiologically with lactation. It gives a reduction reaction with Benedict's solution, a negative blood sugar tolerance curve, and clears up promptly with cessation of milk secretion.

CONCLUSION

1. The absence of glycosuria and hyperglycemia upon arising is extremely common in diabetes.

2. The diagnosis of diabetes will rarely be overlooked if a urinalysis and blood sugar determination is made one to two hours after a heavy carbohydrate meal.

3. A coexistent melituria and normal blood sugar require a glucose tolerance test to make a diagnosis of diabetes mellitus.

4. A falsely positive glucose tolerance test is commonly found in fever, infection, obesity, acromegaly, hyperthyroidism and after starvation.

5. True glycosuria often occurs during normal pregnancy because of a temporary lowering of the renal threshold.

6. A permanently lowered renal threshold is found in "renal glycosuria".

7. In addition to glucose, Benedict's solution is reduced by pentose, lactose, galactose and glycuronates in the urine; this may also follow the use of salicylates, estrogens, morphine, ether and curare.

102 Shanley Avenue

WANT A SOUTH SEAS HOLIDAY?

Civilian physicians are wanted for service in Guam and Samoa. The salary scale is between $7500 and $10,000, and the government will furnish transportation to the south seas for the doctor and his family. Adequate housing is available, and rentals are low. Guam has a 250 bed hospital, and in Samoa there is a 200 bed hospital. For further information write to Division of Territories, Deparment of the Interior, Washingon 25, D. C.

GASTRO-ENTEROLOGICAL PRIZE AWARD

A $100 prize awaits the writer of the best paper on a gastro-enterological topic this spring. Deadline is June 1, 1950. Paper must not exceed 5000 words. Further details are obtainable from —and entries are mailed to— the National Gastro-Enterological Association at 1819 Broadway, New York 23, N. Y.

OPHTHALMOLOGY BOARD EXAMINATIONS IN MAY

May 22 is the date for the next practical examination of the American Board of Ophthalmology. The session will be held in Boston. For details, write to Dr. Edwin Dunphy, 56 Ivie Road, Cape Cottage, Maine.

HAY FEVER TREATMENTS CAN BE HURRIED

Dr. A. L. Maietta recently told the American College of Allergists in their 1950 convention that he had shortened the time necessary to effect tolerance to the ragweed pollen. If the number of injections is reduced to eight, the effects, says Dr. Maietta, are better. He uses an antihistaminic before, after and with the injection. General reaction of the professional audience was: interesting but not entirely proved!

MASS CHEST X-RAY AND FOLLOW-UP—A MUNICIPAL PROBLEM

Irving Willner, M.D., Newark, N. J.

The most powerful instrument in locating early tuberculosis is the x-ray. Minimal lesions without complaints or clinical findings can be suspected by this method. The diagnosis and isolation of the active and infectious case form the basis of a tuberculosis control program. The earlier the infectious process is located, the better the chance for recovery, and the easier the opportunity to treat the source of infection. An ideal procedure would be compulsory x-ray of the entire population at periodic intervals; a normal lung on one occasion does not guarantee that future infection may not occur. Since we cannot achieve this ideal, we do mass x-ray surveys on a voluntary basis, and success is largely dependent upon a preliminary educational program. Screening of a large group of the population does result in the separation of the active and suspicious case from the negative. Not only tuberculosis but other forms of pulmonary, cardiac and mediastinal pathology can be suggested and subjected to further study.

The essence of a survey is looking for the active or suspicious case, and then following it up. Here the government health department with competent chest clinicians, x-ray facilities, social workers, and a public health nursing staff, functions most efficiently. Examining the family and associates of an active or suspicious case may reveal the source of the disease. When voluntary agencies proceed with such a program, close cooperation with the local health department is necessary for effective follow-up.

Voluntary agencies have conducted mass x-ray surveys in various parts of Newark, and large industrial plants have radiographed their employees, usually with 4 by 5 inch films. Conclusions have been reached on the basis of these plates, in spite of the difficulty of accurate diagnosis by this size film. Reports have been made of finding as many as 2 per cent of active cases. In the presence of advanced disease especially with cavitation, the diagnosis based on these small films is usually accurate. Other conclusions are largely dependent upon the experience of the radiologist. A "fuzzy" appearance in the upper part of one lung should be labeled as suspicious. Many cases diagnosed as minimal tuberculosis were, on follow-up study by clinical examination, further x-rays, sedimentation test, et cetera, found to be normal. Some even revealed negative tuberculin tests.

The value of an intensive follow-up cannot be over-emphasized. Suspicious shadows and increased markings were later demonstrated *not* the result of tuberculosis but of other forms of pulmonary, cardiac or pleural disease. Silicosis, pneumonia, virus infection, fungus diseases and malignancy have been discovered after detailed study. That tuberculosis was present was evident in a number of cases and the problem was only whether it was active. This determination is desirable before placing a patient under therapy. Hospital and sanatorium beds are now at a premium and before sending a patient to an institution, we must know whether we are dealing with an active or an arrested case. This can be determined by the clinical and laboratory follow-up and by comparison of follow-up plates. Among food handlers and domestics (where we have a definite control) all suspicious and arrested cases are re-x-rayed every three months in addition to the physical examinations and sputum reports. The arrested case of today may reactivate in the future and a regular routine follow-up is essential.

The screening program is only the *initial* step in tuberculosis control. Without an intensive follow-up, a screening program is a waste of public funds. There has been too much stress on mass x-raying and too little on the follow-up. Many reports have been made of the proportion of minimal, moderately advanced and far advanced cases of tuberculosis found by the screening program. Reexamination will reduce the number and show

that many are inactive, and that others have different forms of lung pathology.

In 1946 by means of a stationary x-ray unit, 4150 chests were examined by the Newark Department of Health. From these plates it was concluded that there were 26 cases of minimal tuberculosis, 11 of moderately advanced, 2 of far advanced and 24 "suspicious". Intensive follow-up led to these final diagnoses: 13 patients had active forms of tuberculosis, 13 were considered questionable and 10 arrested. From June 16 to July 3, 1947, a survey was conducted throughout Newark with a mobile unit furnished by the State Department of Health. During this survey 9916 persons were x-rayed. The program was carefully planned and publicized by radio, press, speeches, wide distribution of pamphlets, posting of placards in buses, and by means of motion pictures in various areas. Purpose of the publicity was to attract as many people as possible to the unit. The mass x-ray program was used for the purpose of a general survey. Where suspicious or active cases were found, more detailed study followed. This consisted of clinical examination, re-x-ray with a 14 by 17 inch plate and sputum examinations. Where further analyses were required, gastric lavage, guinea pig inocculation, tuberculin test, sedimentation rate, et cetera, were accomplished. The original study of the plates indicated 118 cases with minimal lesions, 66 with moderately advanced and 11 far advanced. After the follow-up the conclusion was that only 20 had active tuberculosis, 122 showing arrested cases of a reinfection type and 29 arrested cases of primary type.

An important factor in a mass x-ray program is that other forms of chest pathology are revealed. In the vast majority of cases, the individuals were not cognizant of any of these diseases. The routine procedure is to notify the attending physician when any form of pulmonary or cardiac pathology was located. If the patient had no private doctor, the cases were referred to the health department for follow-up. In 1947, the plates revealed 15 cases of pleural pathology, 22 of diaphragmatic abnormalities, 122 abnormalities of the spine and 345 cases of cardiovascular disease. Only individuals over 15 years of age are x-rayed during any of the programs. For children, tuberculin testing is the procedure with x-raying of all positive reactors and their contacts.

The family physician is an important factor in a mass x-ray program. The close contact of the doctor with the patient will lead to better cooperation with such a program. Distributed literature never has the value of personal advice from the doctor. Confidence can be instilled by a private physician that is not possible by a public agency. Many physicians cooperated and sent their patients to areas designated for the unit. Doctors have been told that they can send any patient unable to pay to the Newark Health Department for x-ray. Report of the plate is sent to the doctor. In all programs, many cases discovered by mass x-ray are of an early or incipient type. These usually respond to treatment and are often inactive and arrested after several months of bed rest. From the public health standpoint it is advisable for the minimal case to be treated at home and by the family doctor. County and state sanatoria are today over-crowded and have long waiting lists. In reviewing cases at sanatoria, we find many of minimal type with negative sputa. Actually the scant supply of beds should be reserved for moderately or far advanced cases where the sputum is positive and where danger of spreading is prevalent with all contacts. At times it is difficult to control the minimal case of tuberculosis at home due to lack of cooperation and due to insufficient funds to engage a family doctor. This problem can be surmounted by strict supervision by the Department of Health. The nurses of the department will keep in touch with the patient. The organized effort of the medical profession is essential for the success of any program.

Routine compulsory examinations were instituted in Newark long prior to any x-ray program. Food handlers and domestics had to be kept free of communicable disease. The program to limit the spread of infectious diseases and so to protect the public from individuals who could disseminate infection by con-

tact, was instituted in 1920. Restaurant employees were originally examined, then grocers, confectioners, delicatessen employees, milk handlers and domestics. Examinations were made for infectious diseases with chief stress on tuberculosis and venereal disease. When any pulmonary pathology was found clinically, x-rays were taken and sputa examined. In 1943 compulsory x-raying of all food handlers and domestics was instituted and a food handler found negative was granted a card permitting him to work for six months. Active cases were immediately rejected and referred for treatment to family physician or the clinics of the Health Department if the worker had no private doctor. Suspicious and arrested cases were granted temporary cards for a three month period at the end of which time they were re-examined and re-x-rayed. Food handlers are x-rayed once a year. During the first five years of this program (from 1920 to 1925) 36,246 examinations were made and 155 active cases of tuberculosis were found and rejected, and 3822 suspicious cases were re-examined. We realize that those food handlers who appear for examinations are reasonably certain that they have no communicable disease. Since the institution of the compulsory x-ray program 88,790 food handlers and domestics were examined with 2081 found "suspicious" and 99 found with active disease and rejected. Most of these examinations were on individuals who had returned regularly for re-examination from time to time in order to obtain their health cards so that there would be a natural reduction in the number of cases found. The reduction must also be weighed against the fact that individuals realizing that they have infectious disease (and knowing they cannot receive health cards) remain away from the Occupational Clinic.

In 1946 the x-ray program was extended to include all admissions to the Newark City Dispensary. All patients, regardless of complaints or diagnosis, received a routine x-ray of the chest. If findings were suspicious, further examinations were made. The number of x-rays have increased from 27,283 in 1945 to 35,188 in 1948. A large segment of the population could easily be reached if all persons admitted to all hospitals would have a routine chest x-ray. A screening of all patients entering clinics should subsequently follow. Such a program would pick up many cases of unsuspected tuberculosis.

One of the major problems is to x-ray individuals most likely to harbor tubercle bacilli. Although many campaigns have been conducted with mobile and stationary units, we realize that the derelict, the chronic alcoholic and the general "floater" found in slum areas and in poor rooming houses, cannot be attracted to the x-ray machines. No legislation can compel these persons to be x-rayed. Literature distributed through these areas and educational pressure have shown meagre results. Even personal contact has been of little value as these "floaters" purposely avoid the surveys. In spite of all obstacles, we sometimes locate them by examination of contacts of an active or suspicious case of a child with a positive tuberculin reaction.

The important factors in a control program are: (1) case finding or location of active cases of tuberculosis, (2) isolation of the active case and treatment, (3) after-care and rehabilitation of the afflicted patient. In following such a program it is essential that those among the population showing the greatest prevalence of the disease have the greatest amount of attention in order to locate as many active cases as possible. Previously, our greatest efforts were among family members and known contacts of infectious cases. By this method many new cases were discovered. Our present effort is to reach as many people as possible and by a mass x-ray program to discover new cases among the general population. The x-ray has assumed increased importance in diagnosing early tuberculosis and has proved itself one of the most effective screening devices.

Mass radiography is one of the prime factors in tuberculosis case finding. The ideal procedure would be to x-ray the entire community. This would lead to the diagnosis, isolation and treatment of *all* infectious cases with the protection of the public from those contacts. No single program is perfect as some individuals may show inactive plates on one occasion

but six months later may reveal active disease. In addition to mass radiography, social and economic problems must be considered as well as living and working conditions and better education.

SUMMARY

The aim of this paper is to emphasize the value of controlled mass x-ray programs in locating pulmonary tuberculosis and the importance of a follow-up of all suspicious and active cases. Surveys can be handled most efficiently by municipalities, provided they are equipped for proper follow-up. By this method many unsuspected cases not known to health authorities can be located. It is not enough merely to suspect disease, we must free the healthy from fear of having it, prove that positive cases exist and then go on to isolate and treat. A survey is also of value to the general population in so far as it gives assurance to most of the people that they are free of tuberculosis. This is essential in terms of preventive medicine.

94 William Street

UTERINE SUSPENSION

A NEW MODIFICATION OF THE SIMPSON OPERATION

M. Edward Baker, M.D., Camden, N. J.

Numerous operations have been devised for shortening the round ligaments in retroversioflexion of the uterus. I have tried them all, often with embarrassing results. The real test of all types of operation for this condition is the effect it has on pregnancy and labor and whether the displacement is likely to recur. During the child-bearing period, the uterus should be suspended if necessary—but never fixed. I always do a suspension operation and I am much opposed to any kind of fixation procedure.

Theoretically the Simpson operation is the one of choice. Unfortunately it is accompanied by too many recurrences to be of any value. Usually during ensuing pregnancies there is a recurrence of the former displacement.

Later laparotomies disclose that the ligaments either pull away from the abdominal fascia or undergo degenerative and atrophic changes due to improper blood supply. The artery of the round ligament was usually destroyed when it was sutured to the abdominal fascia.

I have devised a modification of the Simpson operation. It prevents interference with the circulation of the round ligament and gives good results where the other fails. The entire procedure is carried out as done in a careful Simpson operation until the ligament is to be sutured to the abdominal fascia. Instead of this, I pull a loop or round ligament through the cut fascia, widening this loop with a hemostat. I suture the cut surfaces of the fascia beneath the ligament with cotton, linen or silk. Thus the round ligament is riding in a fascial saddle, supporting the uterus, with its circulation unimpeded by sutures. I have never had a recurrence of displacement following this operation. Recently I performed an abdominal operation on a patient on whom I did a uterine suspension fifteen years ago. I had done the regular Simpson operation on one side and my modification on the other side. At the current operation I found the uterus suspended by only one ligament and that on the side of the modified operation. The other ligament had pulled out and was only a degenerative thread.

I wish to pass this information on to my fellow surgeons. I have found the modification to be very satisfactory.

1149 Kaighn Avenue

DENTAL CROWN IN NASOPHARYNX FOLLOWING ENDOTRACHEAL ANESTHESIA*

I. M. Schnee, M.D., Paterson, N. J.

Aspiration of loose teeth during general anesthesia is not uncommon. But their permanent retention in the nasopharynx is unusual. Sharp and irregular objects might conceivably be caught in the mucosa and be retained there for a long time. Smooth objects may be caught in the fossa of Rosenmuller or in the spheno-ethmoidal recess, but they are ordinarily dislodged after a short period of time. Here is a case of a smooth foreign body, a dental crown, retained for nine months.

A 40 year old male, who had been suffering from chronic suppurative sinusitis since 1943 and was operated on at another hospital in November 1948, presented himself for treatment in May 1949. Symptoms were nasal discharge and headache.

Examination showed residuals of intranasal surgery, purulent discharge from all the sinuses on the left side and scar tissue in the spheno-ethmoidal recess. Nasopharyngoscopic examination revealed abundant scar tissue and synechiae arranged in trabeculae with formation of numerous pockets in roof of nasopharynx. The left middle turbinate was absent. The left ethmoids had been exenterated and replaced by scar tissue. The sphenoid had been opened. This opening is partly closed by scars. The right middle turbinate is also absent. Routine sinus x-rays taken at this time revealed (in addition to the sinus pathology) an opacity resembling a tooth crown in configuration situated in the nasopharynx, below the sphenoid sinus, an inch to the left of the midline and medial to the pterigoid lamina. On comparing films with those taken prior to operation, no such object was seen. However, a metallic upper left lateral incisor is noted in its normal place and relationship. There is close resemblance between this and the misplaced impacted object. The postoperative films reveal a new denture replacing the old one.

Communication from the hospital where patient was operated on stated that in November 1948, a submucus resection, bilateral spheno-ethmoidectomy and antrum window were performed under general endotracheal anesthesia. In the course of intubating the patient (with the aid of an anesthetist's laryngoscope) the gold cap on the patient's tooth broke and the tooth was loosened. Inasmuch as a loose tooth was a potential danger to the patient during operation, that portion which was loose was extracted. Two months later, the re-

Figure 1. Lateral roentgenogram showing dental crown in roof of nasopharynx below floor of sphenoid sinus.

Figure 2. A-P roentgenogram showing dental crown projected on left antrum.

Figure 3. Verticosubmental roentgenogram showing dental crown.

* Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions are the results of the author's own study and do not necessarily represent the opinion or policy of the Veterans Administration.

maining portion of the root was extracted by the dentist. The patient now has a new denture consisting of a crown attached by gold to the tooth on either side.

Since the patient has no complaint or disability resulting from the foreign body impaction, no attempt has been made at exploration and removal.

The metallic crown is obviously imbedded in the tissue as it has thus far been retained for nine months, without changing location.

How it gained entrance into this situation is open to speculation. More exact data concerning circumstances at operation were not available.

The possibilities which occur to us are the following:

1. In the "head-low" position during anesthesia it fell down by gravity.
2. It was aspirated then coughed up into the nasopharynx.
3. It was aspirated into the nasopharynx by the nasal catheter commonly used following endotracheal anesthesia.

Abnormal conditions prevail in the nasopharynx of this patient. There is much scar tissue with trabeculation and pocket formation, thus providing the ground work for foreign body retention.

X-ray examination of the chest was done postoperatively to determine the presence of aspirated foreign body. This is a proper procedure, but apparently one must also be mindful of the nasopharynx when attempting to locate a lost object.

SUMMARY

1. A case of dental crown impacted in the nasopharynx following general endotracheal anesthesia is presented.
2. The methods of entrance and reasons for its retention are discussed.
3. Attention is drawn to the fact that in addition to the chest, the nasopharynx must be considered in searching for a lost foreign body in connection with general endotracheal anesthesia.

586 East 25 Street

CONCERT OF DOCTORS' CHORUS

The Essex County Doctors' Chorus announces a concert on the evening of April 15 at the auditorium of The Mutual Benefit Life Insurance Company, 300 Broadway, Newark. Proceeds of this concert will be turned over to the Essex County Service for the Chronically Ill.

This chorus enjoys a nation-wide reputation as a result of successful performances throughout New Jersey and is one of the few choral groups in the country composed entirely of physicians.

A subscription fee of $5.00 will buy two seats at the April 12 concert. Tickets may be purchased from the Essex County Medical Society, 91 Lincoln Park, Newark 5, and checks should be made payable to that society.

TUBERCULOSIS LEAGUE CONFERENCE APRIL 18

The New Jersey Tuberculosis League announces a spring conference on Tuesday, April 18, at the Essex House, 1050 Broad Street, Newark. The program includes a progress report on the New York Plan, an analysis of the possibility of eliminating tuberculosis from the patient population of our hospitals, the feasibility of routine x-ray screening of all hospital admissions, and the problem of tuberculosis among employees. For detailed program write to New Jersey Tuberculosis League, 15 East Kinney Street, Newark 2.

CASH PRIZE FOR CHEST DISEASE ESSAY

A cash prize of $250 is offered by the American College of Chest Physicians for the best original essay on any aspect of chest diseases. Entries must be submitted to the Award Committee of the American College of Chest Physicians (500 North Dearborn Street, Chicago 10) on or before May 1, 1950. Further details may be obtained by writing to the secretary of the college at the Chicago address.

STATE ACTIVITIES

RECOMMENDED PRACTICES FOR THE CONTROL OF POLIOMYELITIS

At the request of the Public Health Committee of The Medical Society of New Jersey, a joint committee of the State Department of Health, the New Jersey Hospital Association, the New Jersey Nurses Association, the New Jersey State Academy of Pediatrics, and the Public Health Committee of The Medical Society of New Jersey formulated standards for the control of an outbreak of polio. This material was prepared to answer the needs frequently expressed by health officers, hospitals, physicians and others for an up-to-date authoritative reference and guide for meeting practically the many problems related to the control of poliomyelitis, and thus prevent confusion, panic and fear.

(1) According to reports and statistics on the incidence of poliomyelitis by two separate authorities (Dr. Stimson and Dr. Leake), the assumption is that the percentage of permanent paralysis is rarely more than 1 per 10,000 population with the average incidence of poliomyelitis, and rarely more than 1 per 1,000 population in a serious outbreak of poliomyelitis.

(2) Modes of transmission of polio:
   (a) Discharges from the throat, nose and also the bowels of a person ill with or recovering from poliomyelitis and probably similar discharges from a well person who is a "carrier" of the causative agent of the disease.
   (b) Uncooked, unwashed food stuffs may be a vehicle of transmission.
   (c) Insects, particularly several species of the fly, may be be carriers of the virus.

(3) Experience has demonstrated that the closing of schools does not reduce the number of cases of poliomyelitis in a community. In exceptional situations, where there is an unusually large number of infected persons, or where the school buses bring pupils from outlying seriously affected communities, or if there is an outbreak of poliomyelitis in the area of the school which these school buses serve, school opening might logically be postponed. However, it is generally accepted that the orderly supervision of children at school is safer than the indiscriminate mingling of children in community play and in other activities.

(4) Where adequate facilities are not available and the need exists, it is recommended that general hospitals be encouraged to admit acute polio patients, providing they have adequate isolation facilities and medical and nursing personnel.

(5) The following personnel should be made available for the care of polio patients:
   a. Orthopedist
   b. Pediatrician
   c. Internist
   d. Bronchoscopist (for bulbar cases)
   e. Neurologist
   f. Oto-laryngologist
   g. Physio-therapist

(6) Names of polio patients should be treated in the same confidential manner as patients suffering from other diseases.

(7) That the New Jersey Nurses Association be urged to encourage an educational program that will aid in the recruitment and training of nurses for the care of poliomyelitis patients.

THE DISEASE

(1) *Recognition of the Disease*

A highly prevalent infection of which only a small fraction of the cases is clinically identifiable. In its recognizable form an acute illness, usually febrile, with early varying symptomatology, but usually with headache and almost always a characteristic stiffness of neck and spine that justifies an examination of spinal fluid. In about half such cases a lower neurone paralysis develops in first few days of illness which shows a marked tendency for spontaneous improvement after it has reached its height. If first seen after acute stage has passed, diagnosis depends on detection of a flaccid paralysis characteristically irregular in its involvement of muscle or muscle groups. Diagnosis in non-paralytic cases depends upon detection of a clinical picture compatible with the illness plus demonstration of moderate increases in cells in spinal fluid. A form of illness presumptively poliomyelitis (abortive) presenting only vague symptoms and without signs referable to the central nervous system is of frequent occurrence during epidemics.

(2) *Incubation Period*

Usually 7 to 14 days.

(3) *Isolation*

For two weeks from date of onset.

(4) *Reporting*

All obvious and suspect cases should be promptly reported. As soon as possible all of these cases should be classified as paralytic or non-paralytic. For guidance of health officers and physicians the following is proposed:

Diagnostic criteria of paralytic or non-paralytic poliomyelitis should generally include three or more of the following:
(1) history compatible with poliomyelitis
(2) fever

(3) stiff neck and/or stiff back
(4) 10 to 500 cells per c.c. of spinal fluid taken during the acute or early convalescent period of the disease
(5) spinal fluid protein elevated above normal limits
(6) demonstrable muscle weakness or paralysis

Cases which present only (1) history compatible with poliomyelitis, and (2) fever, should be classified as presumptive (abortive) poliomyelitis.

Paralytic cases are defined as those in which definite weakness or paralysis has been detected and persisted during at least two examinations with an interval of at least several hours. Results of an examination for paralysis of muscles of the extremities or trunk may be very unreliable during the period of muscle tenderness or "spasm".

Approved by the Welfare Committee of The Medical Society of New Jersey, January 22, 1950.

Approved by the Board of Trustees of The Medical Society of New Jersey, February 19, 1950.

NEED FOR IMPROVED FACILITIES FOR PSYCHIATRIC PATIENTS IN OUR GENERAL HOSPITALS

HARRISON F. ENGLISH, M.D., Chairman
Advisory Committee on Mental Hygiene

The Advisory Committee on Mental Hygiene of The Medical Society of New Jersey, along with the American Psychiatric Association and the New Jersey Neuropsychiatric Association and many other organizations, lay and professional, advocate the establishment of neuropsychiatric services in general hospitals. Not only would this broaden and improve the medical service and the training facilities of the hospitals but it would bring about the better care of a large group of neglected patients. The neuropsychiatric patient today has as his only choice care in a private sanitarium at an almost prohibitive cost or state hospital care. A psychiatric service would be to the advantage of the hospital as well as the patient, because:

(1) Patients who developed or who were found to have nervous or mental symptoms after admission for some cause could be adequately cared for without the necessity of transfer to a state hospital or private sanitarium. Not uncommonly, very ill patients develop delirium as the result of a toxic condition or drug sensitivity. Not infrequently, a mother will develop a post-partem psychosis. These patients are disturbed and interfere with hospital routine unless the facilities of a psychiatric department are available. However, they often clear up within a few days and it is a great inconvenience to the patient and family to transfer to a state hospital or sanitarium. Physically ill patients may become emotionally upset and sometimes dangerously depressed. They are better managed in a psychiatric department.

(2) The non-seasonal nature of psychiatric cases and the consistency that usually characterizes the rate of admission make it possible to keep psychiatric beds almost continuously occupied. A psychiatric department is one of the best paying departments in a hospital. It is possible for a general hospital to provide a high grade of care at a cost to the patient that is appreciably less than he would have to pay at a first-class sanitarium. This is possible because in a general hospital a large variety of patients are making use of the same laboratory facilities, x-ray department, physiotherapy, and many others.

(3) Psychiatric patients treated in general hospitals are free from the stigma too often attached to admission to a state hospital or sanitarium.

(4) A general hospital has a training and teaching duty to perform for its student nurses, intern staff and also for its attending staff. This training cannot be complete without a psychiatric department.

(5) Psychiatric patients treated in general hospitals in New Jersey may now take advantage of the Hospital Service Plan of New Jersey (Blue Cross).

Any hospital wing can be remodeled to provide proper facilities for the care of psychiatric patients by removing suicide hazards, protecting windows with inside screening and locking outside doors. Facilities for artificial fever therapy, shock therapy, hydrotherapy, consultation and examination offices for physicians and a nurses' station make a complete unit except for provisions for disturbed patients. Disturbed patients, of whom there are few, can be managed wihout restraint in an air-conditioned sound-proof room. One such room for every eight to ten psychiatric patients is adequate.

Until present commitment laws are changed general hospitals will necessarily have to limit their care of psychiatric patients to the non-psychotic, the psychoneurotic patient, who recognizes that he is ill and is anxious to submit himself voluntarily to treatment. Even admission of patients of this kind should be

limited to those who would benefit from a few weeks' hospitalization.

The Advisory Committee on Mental Hygiene, to determine the present status of general hospitals in New Jersey in regard to their facilities for the care of psychiatric patients, sent a brief questionnaire to eighty-one general hospitals during October 1949. The survey was completed in January 1950. The New Jersey Hospital Association cooperated with us. The questionnaire contained only the following five questions:

(1) Does your hospital have a psychiatric service?

(2) If you have a psychiatric service, what treatment facilities do you have?

(3) Does your hospital include facilities for a psychiatric service in its future plans?

(4) If you have such plans for the future, is it likely that they will be accomplished with the next two years?

(5) Do psychotic patients represent a problem of any kind as far as your hospital is concerned?

Seventy-nine of the eighty-one hospitals in New Jersey returned this questionnaire.

Only six reported a complete psychiatric department, that is, one consisting of both in-patient and out-patient departments and providing facilities for shock therapy as well as psychotherapy.

Thirty-three of the hospitals reported some psychiatric service. Thirty-two of these had an out-patient department and fifteen reported an in-patient department. Sixteen administer electro-shock therapy. Eighteen provide psychotherapy. Fourteen provide both psychotherapy and shock therapy. Eighteen of the hospitals that provide some psychiatric service include extension of the service in future plans. Nine of the hospitals reporting no psychiatric service provided for it in their future plans. Nine hospitals reported that they plan to enlarge or begin a psychiatric service within the next two years.

Of the six hospitals that reported the most complete psychiatric service, all were located in the northern part of the state.

The most enlightening replies to the fifth question, "Do psychotic patients represent a problem of any kind as far as your hospital is concerned," are reported below:

One hospital reported that the problem of interpretation to the family of the necessity of transferring a psychotic patient to a mental hospital sometimes takes days and delays arrangement for the transfer, during which time it is necessary to keep the patient in the emergency ward. Another hospital stated that they have no rooms assigned for psychotic patients. They are badly needed inasmuch as when a psychotic patient is inadvertently admitted he is a source of disturbance to other medical and surgical cases.

Another hospital reported, "Our problem is well explained in the following quotation from your letter of October 18, 'The current law does not permit general hospitals to hold patients against their will as is sometimes necessary. There have been instances when potentially dangerous patients have had to be released even though examining physicians found it necessary to observe them further before signing commitment papers.' Also, hospital is not properly equipped to take care of psychotic patients temporarily so that immediate commitment is almost invariably necessary."

Another hospital reported, "There are no special detention facilities for psychotic patients either in our out-patient department or in the hospital. Therefore, the housing of these disturbed individuals in the institution and in the close proximity to the acutely ill patients causes much disturbance. The law says that all attempted suicides must be processed through the police court. Other channels should be established between the courts and hospitals to permit commitment over holiday and week-end periods. In many instances it is necessary to hospitalize disturbed individuals in police cells pending further action. This is certainly unfortunate."

Still another hospital reported, "Lack of adequate facilities for safety and sound-proofing make it difficult for psychotic patients and for the other patients. In certain admissions carefully selected by the attending psychiatrist no difficulties have been encountered."

Another reply reads as follows, "We have neither the facilities, personnel nor the authority to care for psychotic cases for even a brief period for examination, diagnosis and, if necessary, commitment. Doctors and hospitals are at a disadvantage in providing a satisfactory solution for families faced suddenly with this problem."

Still another reported, "Psychiatric patients do present a great problem not only as far as this hospital is concerned but also in relation to the entire community. This hospital is one of the largest voluntary hospitals in New Jersey. It has approximately one hundred forty ward beds and treats a large number of attempted suicides and also a number of patients suffering with long-term illnesses. Our only recourse at the present time is to have one of the psychiatrists diagnose the mentally ill patient and arrange for his transfer to Greystone Park. This is not a satisfactory arrangement and we are gratified to learn that the Medical Society is interested in this problem."

The above quotations and many others from the superintendents of general hospitals throughout the state indicate that the psychiatric patient, particularly the psychotic patient, presents a problem which general hospitals are beginning to recognize and which will require the cooperation of all interested parties, both lay and professional, to solve.

WITH NEW JERSEY MEDICAL AUTHORS

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CORNELL MEDICAL ALUMNI

Alumni day for graduates of Cornell University Medical College will be held on March 23. The scientific program includes operating clinics and presentation of scientific papers, as well as a display exhibit on current research activities at Cornell. For full program write to the Alumni Association in Room F-110 at Cornell University Medical College, 1300 York Avenue, New York 21, N. Y.

OBITUARIES

DR. CHARLES W. HARREYS

Dr. Charles W. Harreys of Ridgewood died on December 31, 1949, at Barnert Memorial Hospital following an illness of several months.

Dr. Harreys was born in Brooklyn in 1877. He was graduated from the Long Island College of Medicine in 1898, interned at New York Hospital and immediately established his practice in Ridgewood. In 1912 he became affiliated with the Barnert Hospital and remained there until 1942, then becoming Surgeon Emeritus. Dr. Harreys was police surgeon for 22 years in Ridgewood, and for 30 years was head of the Barnert Memorial Hospital's eye, ear, nose and throat department. He was also on the staff of the Paterson Eye and Ear Infirmary and on the courtesy staff of the Doctors' Hospital in New York and the Hackensack Hospital. He was a member of the American College of Surgeons, former secretary of the Bergen County Medical Society and Emeritus member of the Passaic County Medical Society.

DR. FRANCIS H. TODD

Dr. Francis H. Todd of Preakness died on January 12, 1950, at the age of 75.

Born in New Haven, Conn., Dr. Todd attended public schools there and was graduated from Yale's Sheffield Scientific School in 1895. Two years later he was awarded a degree by Yale Medical School. He interned at General Hospital, Paterson, and had been a member of the staff for 50 years. He was a former member of the Paterson Board of Health, and was active in local civic organizations. He was a member of the New Jersey Pediatric Society and during World War I served in the Army Medical Corps.

DR. SHERWIN L. HASELTINE

Dr. Sherwin L. Haseltine, who practiced medicine in Elizabeth for 26 years before retiring four years ago, died at his home in Griggstown on January 28, 1950.

Dr. Haseltine was born in Springfield, Mo., in 1887. He was graduated from the Kansas City Medical College and served his internship at the Ophthalmic Hospital, New York City. He was a staff member of three hospitals in Elizabeth, served with the Medical Corps in World War I and was connected with the Elizabeth Draft Board in World War II. Dr. Haseltine was a member of the New York Academy of Medicine and also belonged to the Elizabeth Kiwanis Club.

VIEWS AND REVIEWS

"More Than a Good Doctor"

We suppose that ever since the memorable day when a group of prehistoric men formed the first head hunter's club, the officers of every organization have perennially railed away at their fellow members in the rank and file for their apparent lack of interest in the activities of their organization. Similarly, since time immemorial, the rank and file have gone merrily on their own way, blissfully complacent—insisting that "we elected you fellows to run this organization—now go ahead and do it!".

One could understand the traditional indifference of the average private in the ranks in the good old days when the chief concern of a medical society was to obtain some outstanding speaker for the next society meeting.

But today—when the very future of their profession is at stake—this time honored inertia on the part of the average doctor gives us the creeps.

Recently the *Illinois Medical Journal* had some highly pertinent comments on this situation. We will let the Illinois Medical Journal speak for us:

"State Medicine strictly is a political battle. Most physicians are against it but to date only a handful have done anything about it. A campaign of this nature requires more than all the Whitakers and Baxters in the country; it requires the combined cooperation of us all. The compaign requires the individual efforts of every American physician. The battle will not be won in Washington but by convincing patients and friends at home that State Medicine is bad medicine for the country. To do this every physician must know the facts, pro and con, as well as he knows the symptoms of appendicitis. It is the grass root strategy of campaigning in the local community that 'brings home the bacon'.

"Many physicians think that they are too big to resort to grass root politics; others let it be known that they are so absorbed in the practice of good medicine that they cannot be bothered. We admire everyone who has the welfare of the public at heart but a new variable has been added to alter the picture. In our opinion, State Medicine lowers the standard of medical care and in this respect should stimulate the most conscientious physician to remove his gloves and get in and pitch. Nowadays a physician must be more than a good doctor if he wants to remain a free doctor."

The Medical Society of New Jersey has given every doctor in the state a specific job to do in combating the frauds and fallacies of "socialized medicine". We refer, of course, to the "1-10-20 Plan".

On the constructive side, your Society not only offers the Medical-Surgical Plan of New Jersey which now has an individual enrollment program—but we have also set forth a Twelve Point detailed plan of local action designed to make the voluntary health insurance programs more effective and more generally accepted.

The next move is up to you, doctor.

Common Sense on Health

"There is nothing more devastating to a theory than a few facts" says *Life* Magazine on December 5, 1949, in a brief review of the recently published volume "A Pattern for Hospital Care", comprising the final report of a study of the New York State Hospital and medical care systems by Dr. Eli Ginzberg of Columbia's Graduate School of Business.

Dr. Ginzberg made a fifteen months' investigation of the hospitals in New York state under the auspices of Columbia University and with a state grant of $60,000.

Summarizing its over-all impression of this report, Life magazine states, "The Columbia document collides head-on with most of the assumptions underlying the recent agitation for socialized medicine or for national compulsory medical insurance. It proved that for at least one great state of 14½ million (10 per cent of the U. S. population) American medical service is in pretty good shape."

Moreover, it is noted that Dr. Ginzberg, who received relevant material from 30 other states in the course of making the New York survey, believes that his findings are largely true of a majority of the states.

In *Life's* opinion, "The most outstanding statistic turned up by the Columbia survey is that 57 per cent of the New York state population was covered by some type of voluntary hospital insurance at the end of 1948—and the figure has kept growing throughout 1949."

Eventually, in Dr. Ginzberg's opinion, some

85 per cent of the New York population could be enrolled in Blue Cross or commercial voluntary plans. If this "target figure" of 85 per cent can be approximated in the more populous states, then the case for national compulsory medical insurance would fall flat.

Dr. Ginzberg's specific recommendations appeal to us as highly practical and eminently good sense.

He suggests that the state should subsidize the expansion of services, particularly diagnostic service, for ambulatory patients by making limited grants to hospitals; that it should act to improve the quality of care in nursing homes and other "sub-hospitals" through a better system of state inspection; that the state should improve its services for mental diseases, raise salary scales for professional personnel, and expand training opportunities; that the state should expand its mental hygiene clinics; that it should increase the scope and improve the quality of existing rehabilitation programs; that it should reimburse local government more adequately for its share of the cost of caring for tuberculosis patients; that it should set up a state commission to insure that the public interest in hospital operation is furthered; that it should devote adequate resources to research in every phase of hospital care, particularly problems connected with the effective care of long term patients; and, finally, that it should promote the expansion of training facilities for all scarce categories of medical personnel.

Local governments are urged to "adopt a more liberal approach toward certifying as public charges older patients who could profit from general hospitalization"; improve rates of payment and encourage higher levels of service on the part of private nursing homes and homes for the aged; "pay reasonable fees to voluntary hospitals that provide good diagnostic and therapeutic services to ambulatory patients on public assistance rolls"; improve New York City's facilities for the care of tuberculosis patients; and also (in New York City) take steps to increase the number of people enrolled in voluntary prepayment plans "so as to reduce the pressure for admission for free care in the municipal hospitals".

Dr. Ginzberg sets forth seven recommendations for voluntary groups. The first of these is to improve the quality of hospital care through better control of the work of members of the hospital staff and reduce the costs of hospital care through more effective management. He urges boards of trustees to grant "adequate powers to their hospital administrators and to support them in the exercise of these powers".

Voluntary groups, he feels, should take steps to make facilities of voluntary hospitals "as available as possible to all competent doctors in the community".

He looks to voluntary groups to obtain the necessary funds to experiment in better ways of providing at the lowest possible cost a high level of hospital care, particularly for patients with long term illness and those who can be treated on an ambulatory basis.

In his fourth recommendation, Dr. Ginzberg reminds us "that the continued operation of the voluntary hospital system depends to a very large extent on the expansion of en rollment in hospital prepayment plans that provide adequate coverage for the maximum number of persons".

Voluntary groups, he feels also, should do more to replace obsolete facilities and, at the same time, avoid unnecessary expansion of facilities. He suggests that voluntary groups promote regional councils to bring about better coordination and integration of hospitals.

Finally, he pleads for better cooperation of voluntary and governmental groups working in the public interest in the hospital field.

"Physician, Heal Thyself"

In a recent article, published in the *Journal A.M.A.* by Dr. Frank G. Dickinson, A.M.A. economist and his associate, E. L. Welker, under the title "Leading Causes of Death Among Physicians", the conclusion is reached that "the medical profession is apparently giving to the general population at least as much and at least as good medical care as it is giving itself".

Dickinson and Welker found that among the seven leading causes of death, only in cancer and tuberculosis were the observed rates of death lower in physicians than in persons of the same age groups in the general population. In cardio-vascular disease, on the other hand, the death rates for physicians are significantly higher.

The authors express the view that, in regard to cancer and tuberculosis, "physicians recognize symptoms earlier and begin treatment more promptly" but they characterize heart and cardio-vascular diseases as an "occupational hazard of the medical profession".

Commenting on this study, the *New England Journal of Medicine* remarks that "the significant point is that the mortality in persons trained in medical knowledge — early symptoms, diagnosis, prevention and treatment— is no better than that of the general public in the same age groups. Why," asks the New England editor, "should not the physicians have a lower death rate in all diseases if they profit by their training? The natural assumption is that such trained persons could apply preventive measures, could detect earlier manifestations, could initiate earlier treatment and could thus prolong their span of life".

Our New England contemporary wonders whether part of the answer might be that adequate emphasis "is not placed on personal hygiene and personal preventive medicine in the over-crowded medical curriculum of the day" . . . . "Is it that the physicians become careless of these teachings so far as their own physical condition is concerned in the busy rush of modern life?"

"Is it that in the pressure of practice of his profession the doctor does not find the time to apply these teachings or does not wish to take the time of another physician for the annual examination that might detect the early signs of disease? Good medical practice emphasizes annual physical examinations, but how many physicians have such examinations? These and other questions about the real causes of this discrepancy between physicians and the general population arise".

It should be reassuring to the public to know that the consumers of medical care in America are doing about as well in the line of health maintenance as are the purveyors of that service.

Medical Insurance for Individuals

Now that the Medical-Surgical ("Blue Shield") Plan of New Jersey is embarking upon its long awaited program of individual enrollment, it would be well for physicians generally to understand the hazards as well as the opportunities involved in this development.

The medical profession is just as anxious as anyone to see the people blanketed with voluntary prepaid hospital and medical care insurance. However, as the *Ohio State Medical Journal* remarked recently, "this type of coverage can't be sold exactly as other types of insurance for the reason that the actuarial risk can't be determined quite as definitely. For that reason, care has to be exercised in 'signing up' the individual risk in contrast to signing up groups where the bad risks are offset to some extent by the good ones". Although the premiums on individual policies are slightly higher than for group enrollment, our Ohio colleague points out that "this creates the problem of keeping the cost to the contract holder at a figure which he can afford or is willing to pay".

The timely observation is made that "exponents of wide-open sale of health insurance coverage must keep in mind that no one is going to help the Blue Cross, Blue Shield or the insurance company meet deficits. They are on their own . . . Unlike the government, they can't look to general taxation to help them meet their bills. To do that, would be to ask for, and get, bureaucratic and political control".

Of course, as far as Blue Shield is concerned, the ultimate insurers—the ultimate parties who will have to stand any deficits incurred—are the participating physicians themselves. So far, our New Jersey Medical-Surgical Plan, under cautious and far-sighted management, has been able to carry on its operations in such a way as to pay every physician 100 cents on every dollar since the very inception of the plan. It is to be hoped that this remarkable record of complete solvency may continue. It is conceivable, however, that in the effort to extend this coverage to vast numbers of unscientifically selected risks the time may come when physicians participating in these plans may have to take some small temporary discount against their normal reimbursement for services to these groups.

There is every hope that this contingency can be avoided. However, there is the greater good for the greatest number to be balanced against the temporary loss of some financial compensation.

Freedom has a price, and we suspect the average physician will consider the freedom of his profession and the safety of his way of life worthy of some small sacrifice should such a thing become necessary in the course of expanding the voluntary plans *via* individual enrollment.

Certainly, it is our Number 1 article of faith that, in the words of the Ohio editor, "The whole problem of providing coverage for the individual—the nongroup individual—will be met eventually by the voluntary agencies. That's the real solution".

J. E. B.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, January 13, at 9 p. m., Dr. M. Browne Holoman, presiding.

Dr. Thaddeus L. Montgomery, professor of Obstetrics and Gynecology at Jefferson Medical College, Philadelphia, was the guest speaker. His subject was "Neonatal Care, Including Rooming-In". Dr. Montgomery described, and illustrated with film, the many advantages of this new, yet old, innovation in the care of the new-born. The plan of rooming-in the newly-delivered infant with the mother has been in effect at Jefferson since 1947, and it was the speaker's belief that this early establishment of a normal physiological relationship between mother and infant was an ideal solution to many obstetrical problems. Dr. Montgomery stressed the importance of being guided by physiological principles both in deliveries and in neonatal care. This excellent presentation was discussed by Drs. Norman Quinn and Carlyle Brown. Dr. Holoman, in behalf of the Society, expressed his thanks and appreciation to Dr. Montgomery both for the evening and for his fine work of the past week in the hospital training program.

It was requested by the Secretary of the State Society that the following proposed amendment to the State Society Constitution, Article IV, Section 3, be brought to the attention of this Society for consideration and recommendation:

"The present wording of this section reads: Each component society shall be entitled to one (1) delegate for each fifteen (15) members. The amendment would be a change to: one (1) delegate for each fifty (50) members. There would no change in the minimum delegation of 3 from any county."

The proposed amendment was discussed by Dr. Allman. He stated that it was merely a plan to reduce the number of delegates to the House, that it would give less representation, and that it had no advantages that he could see. He accordingly made the following motion:

"That the Medical Society of Atlantic County inform the Secretary of The Medical Society of New Jersey that it sees no reason for the change in the State Constitution and is therefore not in favor of the proposed amendment."

The motion was seconded by Dr. Salasin and carried.

Dr. Salasin, reporting for the Public Health Committee, announced that another mobile unit chest survey would be held in Atlantic County on the following dates: May 29 and 31, June 1, 2, 5. He moved that the Society sponsor this survey to be held on the mentioned dates. The motion was seconded by Dr. Kline, and carried.

Dr. Murray, reporting for the Post-Graduate Education Committee, stated that no course will be given this year. Probably because of the excellence of the post-graduate program at the hospital, attendance at the last series of lectures had fallen one-third, and their continuation was thought inadvisable at this time.

Upon request of the president, Dr. Allman gave a brief survey of the happenings on the national front in medicine. He spoke of the untiring efforts being put forth to perfect the voluntary Medical-Surgical Plan in New Jersey as soon as possible. He explained why the by-laws of the A.M.A. have been changed to make the $25.00 yearly dues mandatory—the income from periodicals has been unable to keep pace with the steadily rising costs of printing and labor, but even more than that, and now more than ever, we are confronted with the great added cost of combating the menace of compulsory health insurance. He again cautioned the members of the Society against a false sense of security at this stage. The president thanked Dr. Allman, for the Society, for his continued and tireless efforts in this field of activity.

Under new business, approval of the Society was requested for the use of a laboratory appliance known as the Hewson Clinitron, in clinics in Atlantic County but not on Absecon Island. This approval was requested by Dr. Newberry, district supervisor of the State Department of Health, as part of a state-wide survey of bloods for the detection of diabetes. The matter was referred by the president to the committee headed by Drs. Salasin and Major, for disposition.

It was moved and seconded that a request from Dr. Ellis L. Silberman for a leave of absence while completing post-graduate studies at the University of Pennsylvania, be granted. Motion carried.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on February 9, at the Riverton Country Club.

The speaker was Dr. Paul K. Bornstein, a member of the College of Chest Physicians and past president of the New Jersey Chapter. He gave an informal discussion on the subject of *Pitfalls in the Diagnosis of Chest X-rays*. A panel of four "experts" from the Society were asked to "stick their necks out" on some of the chest plates. The whole presentation was enjoyable and instructive.

The Twelve Point Cooperative Health Program which was revealed by Dr. James F. Norton of Jersey City was given the wholehearted approval of the Burlington County Medical Society.

The second Public Health Forum was held in Palmyra on February 10. The topic was "Arthritis", and Dr. E. V. Davis, president, acted as Moderator. The next Forum will be held March 10 in the Medford High School, and the topic will be "Pediatrics".

Dr. Oppenheimer, the new chief of the X-ray Department at Burlington County Hospital, Mt. Holly, was admitted as the newest member.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The West Jersey Hospital was host to the *Camden County Medical Society* at its regular monthly meeting on February 7, with DR. A. M. K. MALDEIS presiding.

DR. RICHARD H. SEELEY was introduced to the Society after taking the oath of membership and signing the roll book. DR. JOSEPH E. ROBERTS, JR., was elected to Honorary Membership in the Society.

The proposals of The Medical Society of New Jersey for a national health and medical care program, as outlined by Dr. Norton, were unanimously endorsed.

The business portion of the meeting was suspended so that the scientific program presented by the staff of the West Jersey Hospital could begin. Dr. Maldeis turned the meeting over to Dr. H. Wesley Jack, chief of staff of the hospital, who in turn introduced the various speakers. The program consisted of the following:

1. *Thrombocytopenic Purpura Hemorrhagica Complicating Pregnancy*—DR. ROBERT N. BOWEN.
2. *The Atrophic Kidney in Hypertension*—
   DR. RALPH S. WRIGHT
3. *Auricular Infarction*—
   DR. ANTHONY J. DIELSI
4. *An Unexpected Diagnosis* (Periarteritis nodosa)
   DR. H. WESLEY JACK
5. *Atypical Leukemia in Infancy*—
   DR. WILLIAM R. PLATT

ESSEX COUNTY

Frank S. Forte, M.D., Reporter

Our president, DR. JOSEPH I. ECHIKSON, spearheaded a move by the *Essex County Medical Society* to establish 10 or more diagnostic health maintenance centers throughout the county for the indigent and medically indigent. At a dinner held in the Suburban Hotel, East Orange, on January 5, mayors and welfare directors of 21 communities together with newspaper writers, service organization representatives and doctors laid the preliminary foundation for this far-sighted project. The idea was well received by all.

On the evening of Thursday, January 12, the regular monthly meeting of the Essex County Medical Society was held in the Academy of Medicine, Newark. The president, Dr. Joseph I. Echikson, presided over a brief business meeting and then turned to the program of the evening. This consisted of a forum entitled "Sex Offenses Against the Juvenile". A splendid presentation was made by the panel which consisted of the following:

Moderator: JOSEPH MURPHY, chief probation officer of Essex County, chairman of State Commission to investigate problems of the habitual sex offender; Speakers—RALPH BRANCALE, M.D., director of Diagnostic Clinic, Menlo Park; JOSEPH G. SUTTON, M.D., director, Essex County Mental Hygiene Clinic; MISS DORRIS CLARKE, chief probation officer, New York City Magistrates Courts; COL. CHARLES H. SCHOEFFEL, superintendent of New Jersey State Police, Trenton; LT. ARTHUR WELLER, Newark Police Department; MRS. FLORENCE PRICE, president, New Jersey Education Association.

A lively question and answer period followed. The program which had been arranged as a public service was a decided success.

The regular monthly meeting of the *Essex County Medical Society* was held on February 9, in the Academy of Medicine, Newark.

After the routine business meeting conducted by our president, DR. JOSEPH I. ECHIKSON, the scientific program was opened. The speaker for this meeting was DR. ARTHUR M. FISHBERG, director of Medicine, New York Beth Israel Hospital and clinical professor of Medicine, New York University. His paper entitled "The Renal Insufficiencies, Their Mechanism and Treatment" was very ably presented and well received. This month also saw new weekly television program over station WATV channel 13, well entrenched. "Know your Doctor", is presented on Wednesday afternoon at 3:15 p. m., and is expected to run about three months. To Dr. Harrold A. Murray, chairman, Public Relations Committee, goes the credit for securing this fine program. Only medical topics are covered by the speakers.

Also well under way is our "Emergency Call Bureau". Dr. Aarron Horland, chairman reports that the bureau averages 40 to 50 calls monthly.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

President J. PAUL BURKETT, M.D., presided at the regular monthly meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, January 19.

A representative from the New Jersey Chapter of the American Heart Association was on hand to explain the program of forming county chapters. It was debatable whether Gloucester County with its small population and limited hospital bed capacity should sponsor a chapter alone or in conjunction with a neighboring county such as Camden. It was voted to table the matter until the next meeting in February.

It was decided to keep the County Society dues at $35 as was passed last May after the state dues increased.

The scientific program was presented by JONATHAN E. RHOADS, M.D., professor of Surgery at the University of Pennsylvania. Dr. Rhoads' paper on "The Acute Surgical Abdomen in Children" was excellently presented and covered all phases of the subject. Many questions were answered by the speaker; a rare treat was missed by those members unable to attend the meeting.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its fourth regular monthly meeting of the season at Murdoch Hall, Jersey City Medical Center, on January 10, with DR. VINCENT P. BUTLER presiding.

The resignation of Mr. Jim Bishop as the Society's Public Relations Counsel was reported.

Dr. Meyerson, chairman, Public Health Committee reported a meeting of his committee on January 9, 1950, when the following recommenda-

tions were made: (1) That the Society endorse the continuation of the present North Hudson Blood Donor Program; (2) that the society appoint Dr. Herman B. Kaplan of Union City medical representative of North Hudson Chapter, American Red Cross; (3) that a report of the North Hudson Blood Donor Program be published in the February issue of the Bulletin.

The Secretary briefly outlined the course in postgraduate medical education which will begin in February under the auspices of Saint Peter's College, Jersey City.

Since a prerequisite for taking the course in Surgical Anatomy is membership in a pathological and anatomical society, the Committee on Postgraduate Medical Education recommended in its report that such a society be incorporated under the name of The Anatomical and Pathological Society of the Hudson County Medical Society. A motion was thereupon made, seconded, and carried, that the Postgraduate Committee be authorized to proceed in the manner necessary to carry out its recommendation.

At Dr. Butler's request, the meeting was addressed by Mr. Nevin, who outlined briefly the program for training in the general technics of public speaking which he plans to direct.

Dr. Butler announced that Dr. J. J. Ruvane co-chairman of the Professional Committee, 1950 March of Dimes Campaign, Hudson County Chapter, National Foundation for Infantile Paralysis, had requested the appointment of a special committee, representative of all parts of the county, to work with him in this humanitarian project. Dr. Butler promised that such a committee would be named, and asked Dr. Ruvane to take the floor. Dr. Ruvane earnestly solicited the assistance of his confreres in making this year's campaign a success.

The scientific session consisted of three papers presented by members of the Society, as follows:

1. *Aerosol Therapy in Infectious Asthma*
   Dr. Benjamin P. Potter
2. *The Pathology of Jaundice*
   Dr. Abraham J. Gitlitz
3. *Anticoagulant Therapy in Medicine and Surgery*
   Dr. Robert Rubenstein

At this meeting, the Society deviated from its traditional procedure of presenting speakers on scientific subjects only, by having as its guest, a well-known figure of the sports world, Mr. Jack Farrel of the New York Yankees.

The following were elected to membership: Dr. Ethel G. Lawner and Dr. Francis P. Salvatore of Jersey City, and Dr. John F. Lewis, Jr., of Hoboken.

HUNTERDON COUNTY

Henry A. Davidson, M.D., Reporter

A twin star bill featured the January 24 meeting of the *Hunterdon County Medical Society* in Flemington. Dr. Royal Schaaf, past president of The Medical Society of New Jersey, and Mr. Lloyd Westcott, secretary of the embryonic Hunterdon County Medical Center board were the speakers. Mr. Westcott brought the society up to date on the progress of the hospital building compaign, pointing out that our little rural county had already obtained pledges totalling almost one million dollars —by voluntary subscription. Dr. Schaaf traced the history of the Medical-Surgical Plan, emphasized the control exercised over the Plan by the medical society—meaning by ourselves, and detailed the provisions of the recently adopted individual subscription contract. A well filled, interested audience plied Dr. Schaaf with practical questions on the operation of the Plan.

A short business meeting was held under the chairmanship of Dr. John Fuhrmann, the society's president. A resolution was adopted supporting the activities of the county school health committee seeking to implement the school health program of The Medical Society of New Jersey.

MIDDLESEX COUNTY

M. F. Leonard, M.D., Reporter

The new president, Dr. H. P. Fine, called to order the regular monthly meeting of the *Middlesex County Medical Society* on January 18, at the Roosevelt Hospital, Metuchen.

Dr. Paul R. Noble of New Brunswick was elected to Associate membership and Dr. Charles Hendee Smith of New Brunswick to Regular membership on transfer from the New York County Medical Society. Dr. Chester T. Brown's resignation from the society was accepted.

Setting aside the rest of the business, Dr. Fine then introduced Philip M. Stimson, M.D., F.A.A.P., associate professor of Clinical Pediatrics at Cornell University, who addressed the society on "Debatable Aspects of Poliomyelitis".

Minutes of two earlier meetings were read and approved after the addition of the Perth Amboy General Hospital to the list of those exonerated in a recent tetanus death.

Dr. J. Van Mater, chairman of the Public Relations Committee announced that reprints concerning the Alamedo County plan for a grievance committee to hear complaints of patients concerning overcharging, etc., would soon be distributed to society members. Some already existing committee of the society, such as the medical ethics committee, might be able to take over this function.

Dr. Kohut, treasurer, announced that the A.M.A. dues of $25.00, for 1950, will be assessed through the State Medical Society and will be payable to the treasurer of the State Medical Society.

On February 15, at the Roosevelt Hospital in Metuchen, the monthly meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. H. P. Fine, at 9 p. m.

Dr. George F. Frederick of Woodbridge was advanced from Associate to Regular membership.

Letters from the Union County Medical Society and the Camden County Medical Society were read, asking the support of our Society for their respective candidates, Dr. Herschel S. Murphy of Roselle, and Dr. Henry B. Decker of Camden, for nomination as second vice-president of the State Medical

Society. After some discussion of merits of a candidate from central New Jersey and of Dr. Murphy's fine record as well as this county's traditional policy of not endorsing candidates in advance, it was decided to refer the letter to the Middlesex County Delegate.

Members were reminded that 1950 dues are payable by February 20. A note from Dr. Wilentz was read, requesting that the 25 per cent of members who have not paid last year's $25.00 assessment to the A.M.A., please do so.

Dr. Fine announced that since the County Society's approval of the appointment of physicians to work in Infant Welfare Stations, only two doctors have volunteered for this work. He urged any physicians interested in cooperating in this program for supplying well baby care to the indigent to communicate with the secretary, Dr. Perillo.

It was stated that Dr. Hutner, chairman of the speaker's bureau was having difficulty obtaining medical speakers for the lay groups throughout the country. All members were urged to participate if asked and to inform Dr. Hutner of subjects on which they would like to speak.

A letter from Dr. Norton concerning a 12 point program for improving medical care was referred to the Board of Trustees to be reported on at a later meeting of the County Society.

The scientific highlight of the evening was an address by DR. MANUEL P. ROSEN, surgeon of the Newark Eye and Ear Infirmary on "The Medical Role of Ophthalmology".

MONMOUTH COUNTY

Lester A. Barnett, M.D., Reporter

A meeting devoted to current medical economics featured the January 25th meeting of the *Monmouth County Medical Society,* held at Monmouth Memorial Hospital, Long Branch. MR. JAMES E. BRYAN, executive officer of The Medical Society of New Jersey, spoke on *State and National Programs for the Current Year.* The principal address, *The Next Phase of Our Fight Against Socialized Medicine,* was delivered by DR. JAMES F. NORTON, president of The Medical Society of New Jersey and vice-president of American Medical Association. A lively and interesting discussion period followed, moderated by Dr. Harry Brindle, president of the county society.

The following were elected to Associate membership: DRS. SAMUEL D. GLAUSS and WILLIAM A. HERBERT of Avon, JOHN J. MOSIG of Belmar and ROBERT B. ROBERTSON of Red Bank. Elected to full membership was DR. HERMAN O. WILEY of Red Bank.

MORRIS COUNTY

Theodore R. Failmezger, M.D., Reporter

The January dinner meeting of the *Morris County Medical Society* was held on January 19 at the Spring Brook Country Club in Morristown, with the aid of cocktails and delicious roast beef. This dinner meeting was held in honor of three new Life Members, DR. JENNIE D. BEAVER, DR. FRANK H. PINCKNEY, and DR. ALVAN SPENCER, who have been members of the Morris County Medical Society for 35 years.

Appropriate remarks were made by Dr. McMahon who presented the members with desk sets in consideration of their faithful membership to the Society.

A motion was made and carried to circularize the Society membership concerning their desire to join a Medical-Surgical Plan of New Jersey as a group.

President TESKEY then presented DR. JAMES F. NORTON, president of The Medical Society of New Jersey, who gave an enthusiastically welcomed address stressing the importance of fostering voluntary insurance plans now in existence.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on January 17, at the Woman's Club, Paterson. IRVING OKIN, M.D., president, presided at the meeting.

Three applicants were elected to Active membership: DRS. THEODORE R. KEITH, PETER J. PIZZI, both of Passaic, and RALPH L. DE LUCCIA, Paterson. DR. PERRY D. COHN, of Passaic was elected to Associate membership.

The Society adopted the following resolution on the death of Charles W. Harreys, M.D.:

WHEREAS: The Almighty God in His Infinite Wisdom, has deemed it best to take from our midst, Charles W. Harreys, devoted husband, and father, respected physician and faithful friend and

WHEREAS: the officers and members of the Passaic County Medical Society feel that the loss of so fine a friend and colleague will be keenly felt by all with whom he came in contact through many years of service and a well-spent life

WHEREAS: his departure makes a severe loss to the community and to those with whom he was associated in his professional and private life.

BE IT RESOLVED: That the members of the Passaic County Medical Society deeply mourn the loss of our colleague, Dr. Charles Harreys and express our heartfelt sympathy to his loyal and devoted wife and to his son.

BE IT FURTHER RESOLVED: This this Resolution be spread in full upon the minutes of this meeting and a suitable copy thereof be presented to his family.

Announcement was made of the intention to vote at the next meeting on an assessment for purchase of the building, permission for which was given at the December meeting.

The scientific session of the meeting was a talk on "Diseases of the Pancreas" by ALEXANDER BRUNSCHWIG, M.D., surgeon at Memorial Hospital and consultant in Surgery at Polyclinic Hospital, New York. Dr. Brunschwig discussed developments in surgical technics for various types of malignancies affecting the pancreas, and illustrated his talk with lantern slide demonstrations of cases at Memorial Hospital.

JAMES F. NORTON, M.D., president of The Medical Society of New Jersey addressed the members on the progress of free medicine in the fight against compulsory, government controlled medical care.

SALEM COUNTY

John S. Madara, M.D., Reporter

The last meeting of 1949 was held on December 16, under the conduction of the society's vice-president, Dr. August Jonas. The entire meeting was given over to Dr. Benjamin P. Potter of Jersey City, a member of the New Jersey Chapter of the American College of Chest Physicians. Dr. Potter gave an interesting discourse on the "Management of Diseases of Chest Commonly Encountered in the Practice of Medicine and Surgery". His discussion included atypical pneumonia, bronchiectasis, lung abscess, tuberculosis, bronchitis, bronchiolitis, and carcinoma of the lung.

December 29, 1949, was a red-letter day for the physicians of Salem County. Many of their dreams came true when the first spadeful of dirt was dug at the Pointers, a spot two miles north of Salem—thus marking the beginning of the construction of the new Salem County Memorial Hospital, with hopes of completion by 1951.

In the absence of the president, Dr. August Jonas, the vice-president, called to order the regular monthly meeting of the *Salem County Medical Society* at the DuPont-Penns Grove Club on January 20.

Dr. R. Louis Silverman introduced the speaker of the day, Dr. Lewis B. Flynn of Wilmington, Delaware, who talked on *Recent Developments in Treatment of Kidney Diseases.* His interesting talk summarized the latest treatment of nephrosclerosis, chronic glomerulonephritis, nephrosis (both lipoid and post-glomerulonephritis), and acute renal insufficiency (lower nephron nephrosis).

Two new applicants were elected to membership: Dr. Ruben Seda-Morales of Woodstown, and Dr. William H. Frazee of the DuPont Company.

Two letters from other county societies were read, pertaining to the nomination of Dr. Murphy and Dr. Decker as vice-president of the state society.

After passing a motion that the annual dues be $45, the meeting adjourned to the dining room.

SOMERSET COUNTY

Irving Klompus, M.D., Reporter

The regular meeting of the *Somerset County Medical Society* was held January 12, at the auditorium of the Ortho Pharmaceutical Corp. Dr. Mason Pitman presided.

Dr. Ernest J. Landry and Dr. Robert Gross were accepted for membership on transfer from Essex and Bergen Counties, respectively.

Dr. Henry A. Craig was elected to Emeritus membership.

Dr. E. G. Brittain introduced the speaker of the evening, Dr. Manuel Lichtenstein of Northwestern University Medical School, Chicago, who spoke on, "Surgical Significance of Variations of the Appendix".

Mr. James Bryan, executive officer of the State Medical Society spoke on the possibilities for the success of legislation on national health insurance.

NEW JERSEY PROCTOLOGIC SOCIETY

Urban Finnerty, M.D., Secretary

At its annual dinner in December, the New Jersey Proctologic Society elected the following officers for 1950:

Dr. A. L. Reich, of Newark — President; Dr. George Becker, of Paterson — Vice-President; Dr. Saul Zager, of Newark—Treasurer; Dr. Urban Finnerty, of Montclair—Secretary.

Dr. Frank S. Forte, of Newark, and Dr. L. Harter, of Jersey City, were elected the Executive Committee.

Dr. Frank Murray, professor of Proctology, Women's Medical College, Philadelphia, gave the first oration commemorating Dr. William Mathews, founder of the American Proctologic Society.

NEW JERSEY SOCIETY OF PHYSICAL MEDICINE

James C. Hanrahan, M.D., Secretary

There was a meeting November 30, 1949, of the New Jersey Society of Physical Medicine at St. Mary's Hospital, Passaic. Dr. Joseph Rubacky discussed "Evaluation of Disability" and presented several cases.

PREVIEW OF PHARMACOPOEIA CHANGES

The Third Sheet Supplement of the U.S.P. XIII has just been released. This gives Pharmacopoeia status to several important new items in advance of the appearance of the U.S.P. XIV, which is to be released in a few months.

The new texts are Penicillin G Sodium and Penicillin G Potassium and also Crystalline Vitamin B_{12} and its Injection.

Penicillin standards became official, on April 1, replacing those previously established by the Food and Drug Administration. Authority for transfer of standards for these two Penicillins, now capable of standardization by chemical methods, was announced by the Food and Drug Administration in the Federal Register of April 13, 1949, page 1770.

The standards for the important new Vitamin B_{12} and its Injection has been given advanced U.S.P. status so that its value in the treatment of pernicious anemia, as compared with that of Liver Injection, might be determined by the U.S.P. Anti-Anemia Advisory Board and prompt controls established.

The Third U.S.P. Supplement will be mailed without charge to all who request it. Write to—

E. Fullerton Cook
4738 Kingsessing Avenue
Philadelphia 43, Pa.

WOMAN'S AUXILIARY

LITTLE BOY BLUE

Mrs. Norman Nathanson, President

There he stood, dripping blue paint from head to foot. A nice shade of blue at that, almost matched his big innocent eyes. My son, age seven, had just been made the victim of his little sister's impulsive whim. Do you have any idea how long it takes oil paint to wear off???

Hannah, our housekeeper, has been gone a month on a much needed vacation. This fourteen room home-office combination has taken on the proportions of Buckingham Palace. My family no longer have faces or personalities—just mouths, stomach, and clothes to be washed. The united efforts of the Joint Chiefs of Staff couldn't possibly begin to compare with the strategy that I must employ when obliged to attend a meeting in a remote corner of our State. When I am finally able to spare a few minutes to sit at my desk to answer last month's mail or write an article for the Journal, I discover "little boy blue" standing by my side! Before I finish this little tale I would like you to think back with me for a minute.

When the Pilgrim fathers landed on our shores in 1620 there were no Democrats to meet them, neither were there any Republicans. None of the Labor bosses or Unions appeared. They didn't start looking for a steam heated apartment with electric lights. They managed without a radio or a telephone. The Indians they saw were dangerously alive and not just whooping it up on television for the kiddies' enjoyment. How about us??? Do we get along without these things? Of course not—after all these are the bare necessities of life. Look around—see what other things we take for granted that they didn't find. So, they took an axe and went into the woods and chopped down trees to build themselves homes. That first winter on our New England shores half their number died. The following Spring, when the Mayflower put out for England, not *one* of that intrepid band returned. They were sold on the future of America. That was the "faith" that has been born in every American, past, present, and, we hope, future!

Now how about you?? Are you sold on the future of a free America? Most of you are. That has been made evident by the excellent work you have done this past year in spreading the truth to your friends and neighbors about the values of free enterprise and the continuation of the practice of medicine free from government control. Well, we can't rest on the work we have done because "here it is"—another assignment! We now have the job of contacting the 1200 P.T.A. presidents in the state of New Jersey with our facts about the dangers of Socialized Medicine. Considering that our total membership is a little over 1500 women I agree that the job is a tremendous one. However, in the face of the trials endured by those who founded and built this land of freedom and opportunity — Gosh. what's a little blue paint after all!!!

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Press and Publicity Chairman

The *Woman's Auxiliary of the Atlantic County Medical Society* in conjunction with the Woman's Club of Atlantic City held a Community Day Tea on Tuesday, January 31, at 2 p. m., at the Hotel Strand. Under the direction of Mrs. G. Ruffin Stamps, chairman of Public Relations, invitations had been sent to all of the organizations of the county.

Mrs. Harry Subin, Program chairman, introduced the featured speaker of the day, Dr. James F. Norton, president of The Medical Society of New Jersey and vice-president of the American Medical Association. Dr. Norton's remarks on the meeting topic "Socialized Medicine—What it would mean for you and for America" was a thought-provoking commentary on what he termed the dangers of such legislation.

Mrs. Benjamin Katzinger, president of the Woman's Club and Mrs. Louis Rosenberg, president of the Woman's Auxiliary to the Atlantic County Medical Society greeted the guests. There were 160 present, representing 50 organizations.

Camden County
Mrs. Thomas M. Kain, Jr.,
Chairman, Press and Publicity

The annual Arts and Hobbies meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held February 7, at the Haddon Fortnightly, Haddonfield.

A covered dish luncheon preceded the meeting with prizes being awarded for the most unusual, the most attractive and the best tasting dish. These prizes were won by Mrs. Keith Haines, Mrs. S. Edgar Howard, Mrs. Elmer E. Geissler, Mrs. Stanford Seto and Mrs. E. W. Clark. Mrs. Oswald R. Carlander was in charge of luncheon arrangements, assisted by Mrs. Leland Stetser, Hospitality chairman, and her committee.

Following the luncheon, Mrs. Florian Douglas entertained with several vocal selections.

Mrs. Betancourt, Membership chairman, then introduced ten new members.

Mrs. Harold K. Eynon, president, conducted the business meeting during which the election of officers took place and the delegates to the convention were appointed. Mrs. A. G. Pratt, chairman of the Nurse Scholarship Committee announced that sufficient funds had been realized from the card party in November to sponsor two more nurse scholarships in September.

Essex County
Mrs. Stuart Zeh Hawkes,
Chairman, Press and Publicity

The regular monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on January 23 at the Robert Treat Hotel, with Mrs. Philip Santora presiding.

Mrs. Philip D'Ambola and Mrs. Harry Di Giacomo, chairman of the Arts and Hobbies Committee presented the program of the afternoon. The program included a delightful play, "The Sentimental Scarecrow" with the following cast: Mrs. Alan Wright, Mrs. Michael Hyland, Mrs. Livio Cosulich, Mrs. Ralph Autorino, Mrs. Pascal Baiocchi, Mrs. Harry DiGiacomo and Mrs. Harry McClusky. Following the play, Mrs. Julius Pearlman played several piano selections. Mrs. Frank Galioto gave a very amusing monologue. Mrs. D'Ambola delighted us with several dances, after which Mrs. C. Joseph Ferri sang to a very enthusiastic audience. The final number on the program was an Exhibition Square Dance featuring Mrs. William DiGiacomo, Mrs. Louis Corvino, Mrs. William Greifinger, Mrs. John Isabella, Mrs. Thomas Santora, Mrs. John Torppey, Mrs. Samuel Pecora and Mrs. Edward Rattene. Mrs. Pascal Baiocchi was the Program Chairman. Tea was served to the one hundred members attending the meeting.

The Nurse Scholarship Project was explained over Station WAAT on the Coffee Club Program on February 13. Mr. Bill Kirby was the interviewer. We were most fortunate in having Miss Margaret Ashmun, Director of Nursing, at the Orange Memorial Hospital, as well as the recipient of last year's award, Anne Carstenson, as our guest. Mrs. Andrew Klein, chairman of the project and her co-chairman, Mrs. Robert White, told about the project in this county.

Hudson County
Mrs. Arthur P. Trewhella,
Chairman, Press and Publicity

At the February 6 meeting of the *Auxiliary to the Hudson County Medical Society* at Murdoch Hall, Jersey City, an interesting travel talk on Italy was given by Mrs. Maria Alliegro, authority on Italian customs and history.

A report from Mrs. Norman Nathanson, state president, was read stressing the importance of organized effort on the part of doctors' wives toward assisting those seeking from us authentic information and guidance in matters of pending legislation and general health problems.

Final plans were announced for the dessert Bridge Party to be held on February 17 at the Masonic Club, Jersey City. Proceeds are to be applied to the Welfare Fund for the establishment of a Nurse Scholarship. Mrs. Louis Norwich is chairman.

Mrs. Fred Sachs, chairman of Public Relations, presented plans for the annual Open Health Meeting to be held on March 6, at Murdoch Hall, Jersey City. A group of Hudson County doctors will conduct a forum on "The Heart of the Matter". Many lay organizations will be invited to attend.

Mrs. John Muccia, chairman of Safety, invited members to attend the Fifth Annual Home Safety Forum to be held in Newark on February 16, sponsored by the N. J. State Safety Council. Hudson county members planning to attend are: Mrs. Sydney Chayes, president; Mrs. Muccia, vice-president; Mrs. William Gleeson, chairman of 1-10-20 Plan; Mrs. Arthur Trewhella, chairman of Press and Publicity; Mrs. Vincent Campana and Mrs. Andrew Pecoraro.

A message from Dr. James F. Norton, president of The Medical Society of New Jersey, urged all members to take an active part in the Emergency Educational Plan to combat compulsory health insurance.

HAVE YOU SUBSCRIBED TO THE BULLETIN?

BOOK REVIEWS

Streptomycin; Nature and Practical Applications. Edited by Selman A. Waksman, Ph.D. Pp. 618. Baltimore, Williams & Wilkins Co., 1949. ($10.00)

Dr. Waksman is to be congratulated for having edited an excellent volume on streptomycin. He and 57 other contributors have assembled in one short book an encyclopedia of information concerning this drug.

Following a brief historical summary, two sections deal with streptomyces griseus in all its aspects. Next the production and isolation of streptomycin are considered, including details of its chemistry, assay methods, and *in vitro* antibacterial action. The effectiveness of streptomycin in experimental tuberculosis and the problems of the development of drug resistance to streptomycin are discussed at length. Pharmacology and toxicity are alloted adequate coverage.

Another section concerns the clinical use of streptomycin, with discussion of the drug in all forms of tuberculosis, including the emergence of drug-resistant tubercle bacilli. Other bacterial infections, however, are not neglected, and each is covered by an authority in his field. The use of streptomycin in non-pulmonary conditions is also described.

The last section covers miscellaneous uses of streptomycin, e. g., virus isolation, veterinary medicine, and agriculture. Related compounds, such as dihydrostreptomycin and mannosidostreptomycin, are also discussed.

This book deserves special praise for its high quality of authorship, the excellent illustrations, and complete coverage of the subject. No aspect of streptomycin is omitted in this fine reference volume.

Rowland D. Goodman, 2nd, M.D.

Diseases of the Heart. By Charles K. Friedberg, M.D., Associate Attending Physician, Mt. Sinai Hospital and Lecturer in Medicine, Columbia University. Pp. 1046. Philadelphia, W. B. Saunders Company, 1949. ($11.50)

In the opinion of the reviewer, this is the most complete and up-to-date of the recent books on heart disease. The theories of compensation and the adaptation of the heart to extra loads are well presented. The subject material is handled so that the reader never loses sight of the clinical side of heart disease. At the same time, the author also includes the more technical details of laboratory diagnosis.

Various circulatory measurements in congestive heart failure are presented for what they are worth. Coronary disease is fully covered, but there is likely to be considerable disagreement with the author about the amount of bed rest necessary in myocardial infarction. There has been a tendency for the pendulum to swing too far towards allowing too much liberty too early in the stage of healing. Blumgart and his coworkers have demonstrated the slow development of collateral channels after myocardial infarction. This confirms the clinical impression of the reviewer and many other cardiologists that rest is necessary for the healing and adjustment of a damaged heart. Possibly such liberal views as are presented on this subject may encourage leniency beyond the point of expediency. It is also questionable whether most cases with myocardial infarction can be treated satisfactorily at home.

In such a comprehensive coverage of a large subject, there are bound to be slight differences of opinions on various subjects and usually both sides of the question are presented by reference to the literature. The frequency of myocarditis was not stressed as much as some would like. The amount of space allotted to this all important cause of deterioration of the strength of the heart was not adequate to discuss all of its ramifications. There is, however, a chapter covering the heart in infections which perhaps explains the brevity of the treatment of myocarditis in the earlier portion of the book.

It would be desirable in a treatise of this size to include some of the more recent experimental work on the etiology of rheumatic disease, but that was probably omitted because of the scarcity of this information in the literature. The author has chosen his material wisely in a practical way for the diagnosis and treatment of heart disease.

All things considered, *Diseases of the Heart* is a readable, interesting, and informative book that may be used for reference or study.

H. C. Crossfield, M.D.

The Diagnosis and Treatment of Adrenal Insufficiency. By George W. Thorn, M.D. Pp. 180, with 32 illustrations. Charles C. Thomas, Springfield, Illinois, 1949. ($5.50)

In a book of monographic size one of the most brilliant exponents of modern medicine and a lucid writer, offers a competent review of up-to-date information on the physiology of the adrenal gland and an orderly, comprehensible assembling of the pathology and pathologic physiology of adrenal failure. The author's wide experience is repeatedly reflected in these pages. He emphasizes the importance of the weight loss, hypotension with or without pigmentary changes as always introducing the possibility of adrenal insufficiency. He evaluates adrenal function by screening and tolerance tests, which are described in detail and physiologically explained. Particularly emphasized is the detection of early Addison's disease. The tests described include those which the laboratory in an ordinary hospital can offer. The effects of the various adrenocortical steroids are compared. Their place in treatment is defined. Current adrenal preparations under the manufacturers' names are evaluated. Even their total cost to the patient is itemized.

The material contained in this small volume is indispensable to the understanding and management of patients with acute or chronic adrenal failure.

Eugene F. Traut, M.D.

Book Reviews continue overleaf.

Selective Partial Ablation of the Frontal Cortex. Edited by Fred A. Mettler, M.D. Hoeber, New York, 1949. (517 pages) ($10.00)

New Jersey has made a substantial contribution to medical progress in furnishing all of the material and much of the personnel of this pioneer topectomy project. Topectomy is a technic of selective ablation of parts of the frontal cortex. Of 24 patients subjected to this operation, 20 could thereafter be paroled from the hospital. Of 24 non-operated controls, (matched to the operated group) only five could subsequently be released from the hospital. All of the subjects were long term psychotics who had failed to improve substantially under shock therapy, psychotherapy, and institutional regime.

All patients received an elaborate, psychiatric and psychologic study before and after operation. The amount of work which went into these studies, the care taken to match subjects with controls, the unblinking honesty of the entire project, are all worthy of the best traditions of medical science. The project reflects something else, too: the richness and effectiveness of cooperative team work.

New Jersey's role was a considerable one. Our State Department of Institutions and Agencies placed the facilities of Greystone Park at the disposal of the researchers. The entire project came out of a course given by Dr. Mettler under the auspices of the New Jersey NeuroPsychiatric Association. The Veterans Hospital at Lyons, New Jersey made a material contribution to the success of the study. Of the 43 contributors whose collaboration resulted in this book, sixteen are from New Jersey.

The book itself is a large volume, profusely illustrated with some of the finest charts, photographs, x-rays and diagrams ever offered in the field of neurosurgery. There are numerous actual operating-table photographs of exposed brain areas before and after ablation. The operation itself is described in minute detail. The chapter on cytoarchitecture is probably the first in all medical history to define histologically the extent and location of specimens taken from the human frontal cortex in any large number of cases.

Hundreds of books are offered by medical publishers every year. But only once in a few years does any book really represent an actual pushing forward of the frontiers of medicine. This is one of them.

J. SANTANGELO, M.D.

Acute Laryngotracheobronchitis. By A. Harry Neffson, M.D. Pp. 197. New York, Grune & Stratton, Inc., 1949. ($5.00)

Acute laryngotracheobronchitis is often a deceptive disease which demands alertness and action on the part of the doctor. Early it may appear to be an innocuous upper respiratory infection and the diagnosis may be missed at a time when medical treatment is of great value, especially if the importance of hoarseness or dyspnea is overlooked.

In this monograph the author makes laryngotracheobronchitis a clear and unmistakable entity. If it is not always so in clinical practice, a reading of this book should place the pediatrician, the general practitioner and the laryngologist (the roles of each of which is clearly set forth) into such a position that accidents of diagnosis or management which slim the margin of recovery in this dangerous illness do not occur. The disease is discussed from every angle in a clear and forthright manner.

In the chapters on treatment varying methods are presented. The important often-overlooked aspects of medical management, as well as those of surgical emergency, such as in intubation, tracheotomy, bronchoscopic and laryngoscope suction, are discussed. It is emphasized that the cases are highly individualized as to choice of treatment. The special pathology present in the larynx and surrounding tissues, the skill, judgment and availability of the attending physicians, are factors in the choice of treatment.

The seriousness of the disease is brought into sharp focus by the inclusion of a chapter on complication of treatment. This book is highly recommended to all who are called upon to treat respiratory illness, especially because the opportunity for learning about these cases by clinical experience is small and costly.

LOUISE FISCHER, M.D.

Marihuana in Latin America. Pablo Wolff, M.D. Linacre Press, Washington, D. C., 1950. Pp. 56. ($1.50)

Most North American psychiatrists underplay the threat of marihuana addiction, in the opinion of Dr. Wolff, who is an Argentinian authority on the subject. He believes that the drug exercises a serious and deteriorating effect on the personality of the chronic user, and this short pamphlet is a brief for the prosecution in the attack on marihuana traffic. While Dr. Wolff agrees with most of his North American colleagues that the drug does not produce a "physical dependency", he is disturbed by the "psychic dependency" which he says, produces an "almost irresistible desire to obtain the drug". Its victims, he says are "nothing more than human scum". No plan of treatment for the addict is suggested in the booklet.

HERBERT BOEHM, M.D.

Handbook of Medical Management. Milton Chatten, M.D., Sheldon Margen, M.D., and Henry Brainerd, M.D. Pp. 478. University Medical Publishers, Palo Alto, California, 1950. ($3.00)

Since this *vade mecum* is certain to get rough handling in the bag or pocket of the physician, it is unfortunate that the publisher did not bind it more substantially. The cardboard covers will not last long if the reader leafs through the volume as often as he should. Packed into this meaty manual is an enormous amount of useful medical information. There are chapters on the diseases of each major system with down-to-earth tips on diagnosis and treatment. The back cover features a ready reference dosage conversion table and the inside flap shows normal hematologic values. Any busy practitioner who looks through this volume must agree that it is well worth pocket-space.

VICTOR HUBERMAN, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **March, 1950** **No. 3**

EVIDENCE that the practice of X-raying the chests of all patients admitted to general hospitals is an efficient means of discovering unsuspected cases of tuberculosis continues to accumulate. The procedure not only aids the physician and gives the patient the benefit of early diagnosis; it also protects hospital personnel and advances the control of tuberculosis in the community.

ROUTINE CHEST PHOTO-ROENTGENOGRAPHY IN BARONESS ERLANGER HOSPITAL, CHATTANOOGA, TENNESSEE

Early in 1946, Baroness Erlanger Hospital in Chattanooga accepted as a permanent loan from the State Department of Public Health in Tennessee photo-roentgen equipment for the purpose of doing routine chest roentgenograms on all persons admitted to the hospital. At that time, the Chattanooga-Hamilton County Health Department was operating a stationary photo-fluorograph for clinic use and a mobile unit for the roentgenographic examination of persons in industry, schools, and the community. The equipment placed at the general hospital, therefore, rounded out the case-finding program and made routine chest roentgenograms for the discovery of cases of tuberculosis available to another population group.

Procedure

The stationary 35 mm. photo-fluorograph in the health department clinic is used to examine contacts of known cases of tuberculosis, food-handlers, teachers, barbers and beauty operators, persons applying for employment in certain industries, patients referred by physicians, persons desiring roentgenograms because of symptoms or for some other reason, a few students referred from schools, and a miscellaneous group. The individuals included in this survey are designated the Health Department Clinic Group.

The groups surveyed by the mobile unit are classified as community, industrial, or school. The community group includes adults living in residential areas of Chattanooga and Hamilton County. The industrial group consists primarily of workers employed in manufacturing plants. In the school group are students 15 years of age or over. The three subgroups are combined as the Mobile Unit Group.

The plan to obtain chest roentgenograms routinely on all persons admitted to the Baroness Erlanger Hospital was not attempted at first. Employees and any nonpaying patients (primarily indigent), a few private patients, and persons referred from the emergency room were included in the first survey. This group of persons is designated the Hospital Group.

Analyses of the clinic and mobile unit groups are for the year 1946, and that for the hospital group is for the period April 1 through December 31, 1947. This report seems indicated because of the relatively high percentage of pulmonary tuberculosis discovered in the group examined roentgenographically on admission to the hospital.

Results of Photo-roentgen Examinations from Three Types of Surveys, Chattanooga-Hamilton County 1946-1947

Group	*Number Examined*	*Cases* Number	*Cases* Percent
Health department clinic, 1946	13,966	383	2.7
Mobile unit, 1946	14,293	290	2.0
Hospital unit, 1947	5,187	193	3.7
All surveys	33,446	866	2.6

Discussion

The highest percentage of cases of tuberculosis (3.7) was found in the hospital group, but this

should not minimize the finding that 2.0 and 2.7 per cent of persons examined in the mobile unit and clinic groups had tuberculosis.* Surveys such as this have proved their value repeatedly during recent years. Routine roentgenographic examination of hospital admissions, however, has not received the attention it merits. The risk to the medical student, nurse, or hospital employee of cases of unrecognized tuberculosis in the hospital population has been noted, but all too often the exceptional opportunity for tuberculosis case finding provided by the hospital population has been overlooked. Unrecognized tuberculosis among hospital employees and patients imposes a responsibility upon the hospital that is difficult to ignore.

It is interesting to compare the make-up of the hospital survey group and the health department clinic group. In no subgroup of the mobile unit group has tuberculosis been found to be higher than 2.7 per cent. There is no outpatient tuberculosis clinic at Baroness Erlanger Hospital, and patients are admitted for hospital and clinic services for complaints other than tuberculosis. Except for diabetes, tumor, and venereal disease clinics (which might be expected to have considerable unrecognized tuberculosis), there was no special subgroup that contributed to the high percentage (3.7) of persons found with tuberculosis in the hospital population. On the other hand, the health department clinic examined such subgroups as contacts (5.5 per cent with tuberculosis), barbers and beauty operators (7.7 per cent), and patients referred by physicians (9.3 per cent), in all of whom cases of tuberculosis are discovered frequently. This makes it more apparent that routine chest roentgenographic examinations of patients admitted to general hospitals should be seriously considered as a responsibility of the hospital and its contribution to the tuberculosis control program.

The success of any tuberculosis case-finding program depends upon the finding of early cases of the disease. In the clinic and mobile unit groups 65 to 70 per cent of the lesions discovered were minimal in extent. It was surprising to find that among the hospital population examined, 92 per cent of the lesions discovered were classified as minimal. In only 7 per cent of the patients were the lesions moderately advanced, and in only one per cent were the lesions far advanced. Of the total number of cases of tuberculosis discovered, 21 per cent were active lesions of minimal extent. The amount of tuberculosis found among young adults was high in the hospital group.

With the advent of photo-fluorography it was expected that many general hospitals would take advantage of this economical technique and adopt chest roentgenograms as a routine procedure. This has not occurred. While mass radiographic procedures are taken for granted in other population groups, there still seems to be some reluctance to use routine chest roentgenography on general hospital patients. This reluctance is difficult to understand. It appears that this one population group has been handed to those seeking out unsuspected cases of tuberculosis in the community "on a silver platter".

*Editor's note: These percentages refer to reinfection type tuberculosis, but it should be noted that this does not mean that all cases were clinically significant.

Routine Chest Photo-roentgenography in Baroness Erlanger Hospital, Chattanooga, Tennessee, Paul M. Golley, M.D., The American Review of Tuberculosis, September 1949.

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Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal.* All such communications should be directed to the Editorial Office of *The Journal.* The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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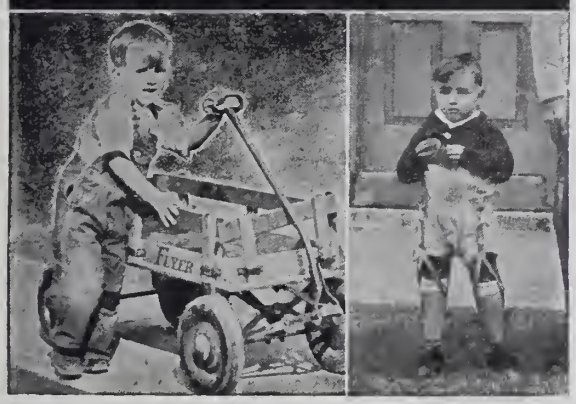

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CONTENTS—Pages 145 to 190

EDITORIALS— Page

Toward Effective Cancer Control . 145

Norman M. Scott, M.D., 1889—1950 .. 146

National Disability Insurance 147

ORIGINAL ARTICLES—

This Last Best Chance on Earth—G. Brock Chisholm, M.D., Ottawa, Canada 148

Trichinosis with Heart and Lung Involvement—Harold H. Goldberg, M.D., Newark, N. J., and David Biber, M.D., Union, N. J... 152

Surgical Treatment of Pulmonary Tuberculosis—George N. J. Sommer, Jr., M.D., Trenton, N. J. 154

Aphthous Stomatitis Treated with Aureomycin—Max Braitman, M.D., West New York, N. J. 160

Dicumarol in the Treatment of Heart Disease Complicated by Pregnancy—Harry M. Schneider, M.D., Jersey City, N. J..... 161

Cough-Pain Sign in Thrombophlebitis—Elias D. Lawrence, M D., Paterson, N. J..... 164

Avulsion of the Biceps Tendon — Theo. Schlossbach, M.D., Ocean Grove, N. J..... 166

ORIGINAL ARTICLES— Page

Unusual Reactions with Antabuse—Robert S. Garber, M.D., and Robert E. Bennett, M.D., Trenton, N. J. 168

Calcification of the Prepatellar Bursa—Hugh M. Babbitt, M.D., Plainfield, N. J..... 170

The Standard Nomenclature of Diseases and Operations — Jacob L. Balk, Emanuel Klosk, M.D., and Arthur Bernstein, M.D., Newark, N. J. 171

STATE ACTIVITIES—

Board of Trustees Meeting 175

Autopsy Administration 176

Radiologists Protest our Hospital Editorial.. 179

Supplementary List of Members No. 1 180

Honor to Dr. Charles Schneider 181

To the Ladies 181

PUBLIC HEALTH NEWS 182

COUNTY SOCIETY REPORTS 183

WOMAN'S AUXILIARY 185

BOOK REVIEWS 187

TUBERCULOSIS ABSTRACTS 189

Roster of Officers, Advertising Page 3 A

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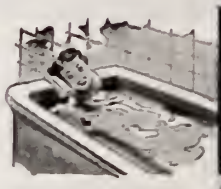

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The physiological observations of the influence of carbon dioxide baths show a decrease in the pulse rate, an increase in the pulse pressure dependent mainly on a drop of the diastolic pressure, a better emptying of the venous blood vessels, a hyperemia with increased capillary circulation, a slightly elevated minute volume output of the heart, an increase in respiration and the elimination of large quantities of the carbon dioxide through the lungs.

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As printed in International Clinics, Vol. 1, page 199, March 1937

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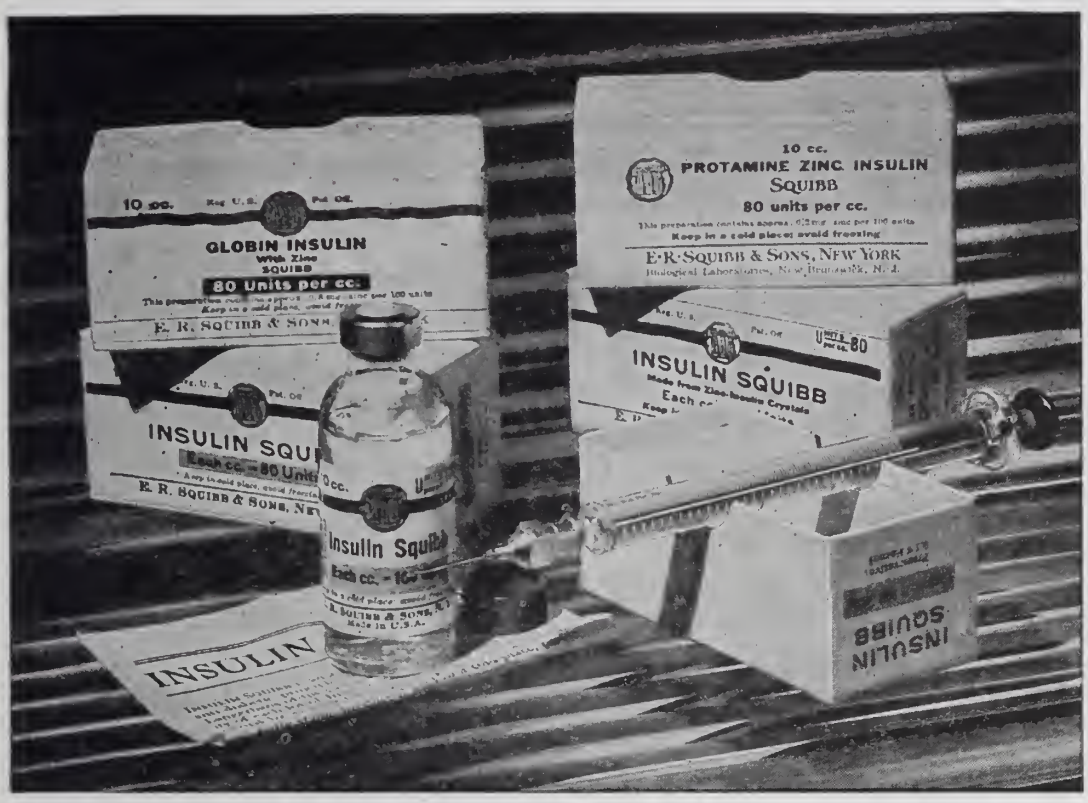
Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



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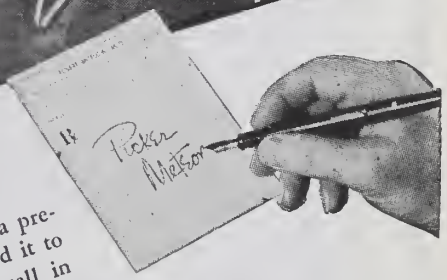

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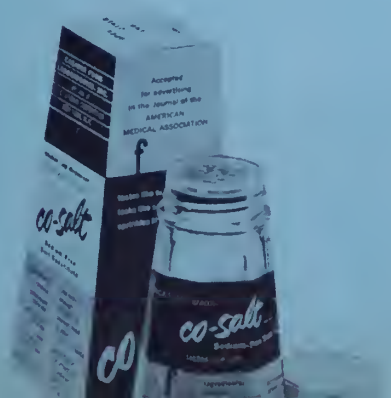

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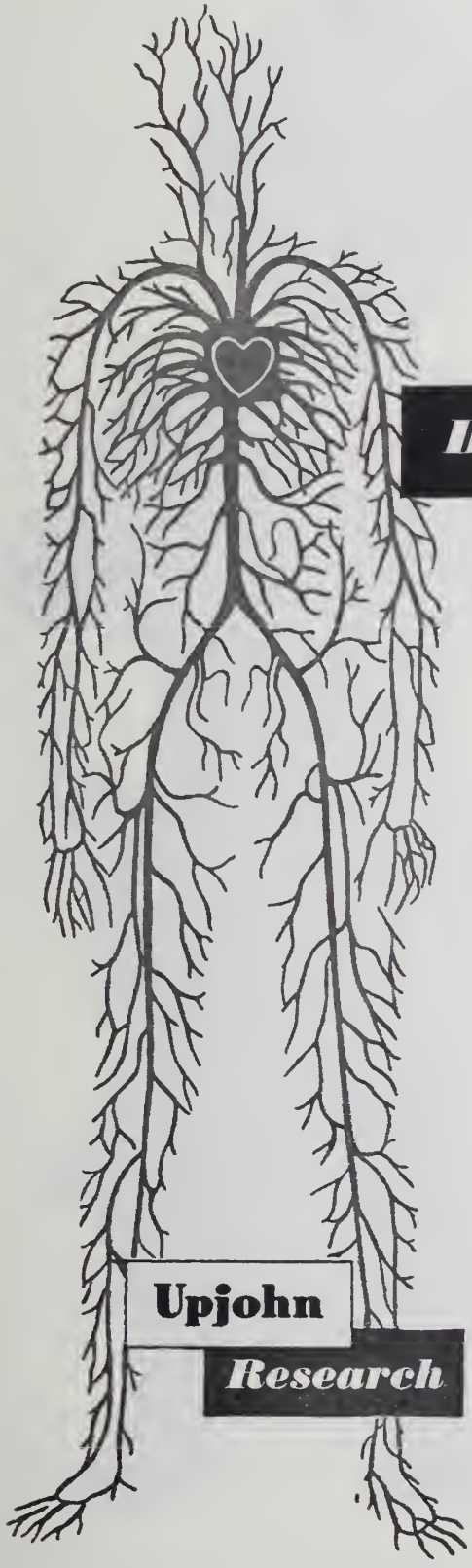

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1. A Study of Enriched Cereal in Child Feeding. Urbach, C. Mack, P. B., and Stokes, Jr., J. Pediatrics 1:70, 1948.

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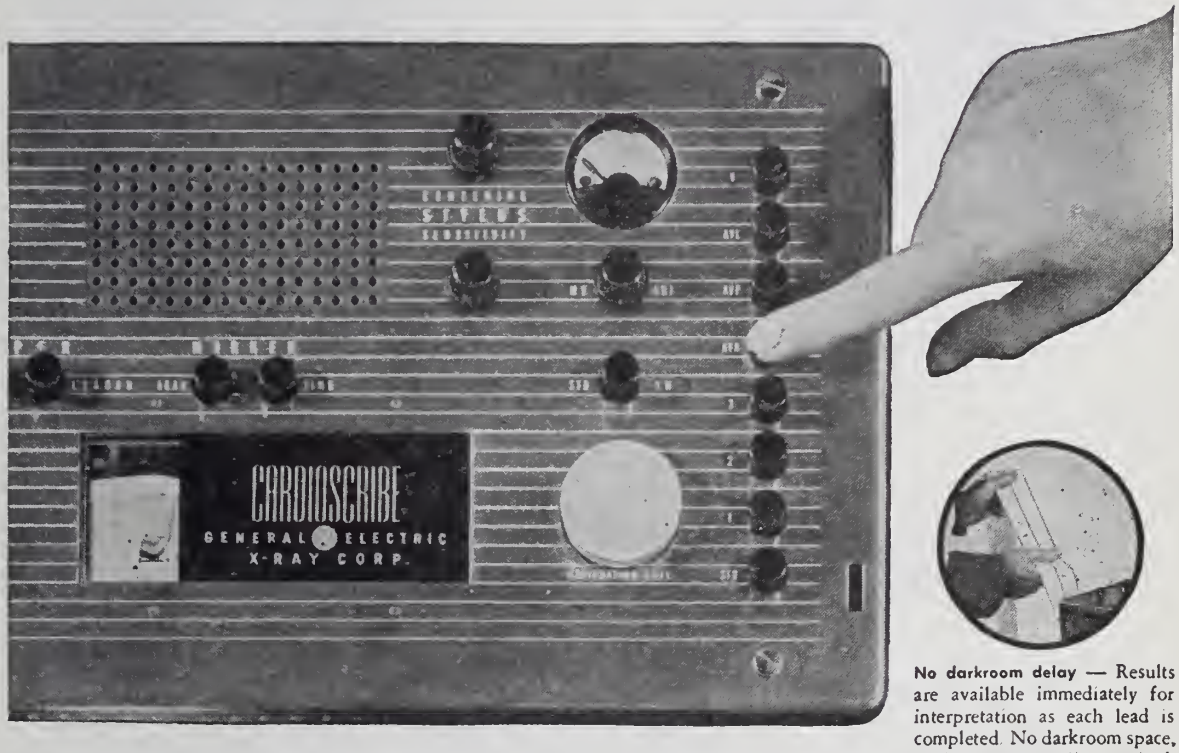

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TOWARD EFFECTIVE CANCER CONTROL

Nowhere in the world do voluntary health agencies abound as they do in the United States. They are an expression of the kindliness of our people toward those less fortunate, and they are testimony to the democratic spirit in organizing and working cooperatively for the common good.

The American Cancer Society, a venerable member of the family of health agencies, should be thoroughly known to all doctors for its services are many. Through its 61 chartered divisions and 2,613 county branches, it conducts a broad-based year-round effort to control cancer. The control of cancer eventually will come through an understanding of causes, means of prevention and effective treatment methods; this knowledge waits on research. The Society has recognized the importance of intensified investigative efforts and spends 25 per cent of its income in the support of such studies and in the training of young scientists to carry them forward. During 1950 this support will amount to $3,500,000. Total research expenditure for the past five years tops 13 million dollars.

The disparity between cancer's *curability* and the cures being achieved is striking. For example, cancer of the breast is curable in 80 per cent of patients treated when the disease is confined to the breast; yet the country-wide cure rate is less than 35 per cent. When cancer of the rectum is confined to the mucosa, cure rates of 70 per cent are reported; yet the overall rate of cure is only 11 per cent. Similar differences hold for most forms of the disease. To achieve a

larger measure of cures, the American Cancer Society engages in an intensive educational and publicity campaign, based on knowledge of cancer's early signs and symptoms and the value of periodic physical examinations.

Improved services to patients are provided by the Society's support of cancer clinics, organized programs of cancer detection and information services; these efforts are augmented by a corps of volunteers who provide loan closets, transportation services, recreational activities and dressings.

During the past year, three monographs of a series dealing with cancer by anatomic site have been distributed to practicing physicians throughout the country. The series will be continued with distribution at three-month intervals.

A series of motion pictures for professional audiences, treating the problems of early diagnosis of cancer by anatomic site, has been outlined. Two of the films have been released, the first concerned with the general problem of the early diagnosis of cancer and the second concerned specifically with the early diagnosis of cancer of the breast. A third, covering cancer of the gastro-intestinal tract, will be released this year.

The Library of the Society publishes monthly a bibliography of the current cancer literature available to all physicians. The library will prepare, on request, bibliographies on any topic related to the field of cancer. A package lending library has been established which will supply reprints, on a loan basis, to any physician or investigator requesting the service.

By the way, April is the month of the Annual Appeal of the American Cancer Society.

NORMAN M. SCOTT, M.D., 1889—1950

A colorful and effective career of medical service came to a close with the death of Dr. Norman M. Scott last month. A formal obituary on Dr. Scott will appear in the June Journal. However, it is not fitting that we let this issue go to press without marking in some way the passing of one of the most valuable officials of organized medicine in the country. Although we naturally think first of Dr. Scott's enormous contributions to medical plans in New Jersey, he actually enjoyed a nation-wide reputation as an expert in this complex field: one who combined to an exceptional degree the professional medical background, the administrative skills and the body of economic knowledge which are needed for the efficient organization and operation of voluntary health insurance plans.

After a successful career in the regular Army, one which included daily surgical practice as well as staff and command functions, Dr. Scott entered the service of The Medical Society of New Jersey in 1938. He has thus been with us during twelve of our most trying years. He was in at the birth of Medical-Surgical Plan and Medical Service Administration. He nurtured these lusty infants and was largely responsible for their vigorous growth. With diplomacy, skill and a sense of humor, he kept in neat balance the conflicting personalities and issues which always seem to surround the organizational struggles of health insurance plans. He was uniquely equipped for this service and such a combination will be hard to find again. His death is not only a personal shock to his many friends: it is a serious loss to the staff of The Medical Society of New Jersey.

NATIONAL DISABILITY INSURANCE

There is now before the Congress a proposed amendment to the social security act. Bearing the neat number, HR-6000. the bill is primarily a social welfare proposal, covering old age and unemployment benefits. It also has one section of intimate interest to medicine: a chapter which provides for compulsory, contributory, disability insurance. Organized medicine's attitude towards this is well summed up by a statement recently released by the A.M.A. Board of Trustees, which seems well worth quoting verbatim:

"The major benefits included in the present social security system—old age and unemployment — are adaptable to mass or objective administration from an office remote from the individual. This is not true of total and permanent disability benefits. Age is a condition over which the individual is unable to exercise any control, and unemployment is an occurrence over which the individual may have little or no control. Qualification for the benefits is categorical and not difficult to determine. In contrast, total and permanent disability is often a condition over which the individual and his physician may exercise control.

"This subjective control which may be exercised by the individual multiplies the opportunity for malingering and actually takes the program out of the insurance category. We oppose any program which places a brake on the incentive of the sick and disabled to desire recovery.

"To initiate a federal disability program would represent another step toward wholesale nationalization of medical care and the socialization of the practice of medicine. The program as now proposed would not accomplish the entire nationalization of medical care but the inevitable expansion and liberalization of the program which would surely follow makes probable its eventual accomplishment. The steps in liberalization are not hard to visualize—such as payment of benefits to dependents of covered persons, removal of the time lag of six months and substitution of temporary disability benefits, then eventually full cash sickness and disability provisions. We would then have nothing less than a national compulsory sickness program.

"During the hearings on this bill persons fully qualified in the field of economics and insurance and students of political science warned against the high additional percentage of national income to be committed by the enactment of extensions as proposed by H.R. 6000. Of this danger, we are aware.

"The American Medical Association recognizes the need for assistance to the disabled needy and feels that this aid should always be administered on a local level. Financial assistance to the locality should only be advanced from state or federal sources when a need can be clearly shown."

ORIGINAL ARTICLES

THIS LAST BEST CHANCE ON EARTH *

G. Brock Chisholm, M.D., Ottawa, Canada
Director-General, World Health Organization.

There is a long history in the human race of fighting, between individuals and groups, as effectively as they know how in each stage of their development. In the past, that was not too important, even when a gross neurotic who was badly in need of excessive degrees of power, was able to gather around him sufficient minor neurotics so that he could lead them and conquer large parts of the world. He killed people at retail rate—not wholesale. It is true that there were some notable retail killers in the past—people like Alexander the Great, Genghis Khan and many others. But they had little racial effect; they did not cover whole races.

Recently the human being has learned to kill more effectively. There is nothing new in his desire to kill, or in his practicing that power frequently and enthusiastically. There is an old military saying that defense always overtakes the offense. Actually that has never been true. What has happened is that more efficient offense has overtaken obsolete offense—not defense. But when offense has become absolute so that it is possible to kill full populations, as it is now—then there is no further to go! Fighting as a method of survival—the whole business of competitive survival—has become an obsolete human behavior pattern. If it continues one more generation as it was in this generation, the human race may disappear or be put back so many millenia in their development that their evolution will have to start all over again.

Fighting and suicide have become synonomous. *There is no way of winning a war in the future—of anyone winning a war in the future.* One might well wonder in fact, who won the last war. The people who are living the most comfortably now are not necessarily at all the ones that were on the winning side—not necessarily at all! *There will be no doubt in any future war that everyone will lose.* The *atomic bomb is quite obsolete* and has been for at least three years. Biologic warfare is so much more effective that the atomic bomb may appear as child's play compared to the killing potentialities of biologicals now available.

Biologic warfare makes any little country that has available one expert bacteriologist and a few fanatical distributors just as potent in any future war as the United States or the Soviet Union. Any country in the world is just as potent now as any other country, from a military point of view. Armies, navies, air forces, heavy industries, are completely irrelevant to any future war. It is from now on impossible for any group of people, by force, to run any other group of people except at the expense of racial suicide. The conditions of survival today are as different from the conditions of survival of ten years ago as they are from those imposed by the Ice Ages, which changed the whole circumstances and environment of large numbers of organisms. In the Ice Ages very large numbers of creatures did not survive. In this new age the question is this: will the human race sufficiently readjust their whole relationship to reality soon enough, so that there can be some reasonable assurance that our children may be able to exist on this planet? That is not to be taken for granted. We have taken so much for granted. We have taken for granted that

* Abstracted from a talk delivered at the High School, Montclair, N. J., October 10, 1949.

this universe was made for man—that man represents the height of evolution. May we remind ourselves that many forms of life lived much longer on earth than man has lived. But when circumstances changed they could not adjust themselves to a sufficient degree. They died off. Man may well do the same thing and leave room for some more adjustable organism.

On the other hand, man may be able, soon enough and widely enough, to do something about himself, so that he may be able to survive. Man has learned over a million years to compete with other forms of life quite successfully. Long ago man gained ascendancy over the other large animals, many of them much larger than himself. Now there are no large animals left to compete with man at all. They are alive by sufferance in zoos for man's education or pleasure or in reservations. . . . Even the very small animals, the bacteria, man has learned to control in most cases. He has not defeated them; he has not defeated any of the bacteria. He has learned to control some of them. He can control such bacteria only by a continual and permanent manning of his defenses. Already one begins to hear people saying: There has been no diphtheria in our town now for the last ten years; why should I have my children inoculated? Or—I have never heard of a case of smallpox in our county or state for many years,—isn't it foolish to go on vaccinating our children? If we should go on just a little longer that way and stop vaccinating our children or toxoiding them, or using the other methods we have for control, these things would all come back again. They could sweep over populations again and kill millions of people. For we have not defeated any of these little organisms; we have learned how to control them as long as we remain alert and use the methods available for this purpose.

Man in dealing with himself has not used the same methods he has used in dealing with other specimens. No one thinks of classifying the rat which carries the flea, as a criminal, or saying he should be punished. He is just painlessly put out of the way. Unfortunately all man's behavior has to be classified on a moral basis—that behavior is not judged as to what it will do to the human race, but whether it is good or bad according to the criteria of some previous generation handed down according to the attitudes of people who know nothing about the present circumstances at all.

The consciences of intelligent people tell them different things under the same circumstances. Quite different! No Eskimo ever found his own conscience in a Presbyterian nor a Presbyterian conscience in an Eskimo, unless a little child of a Presbyterian family at birth had been put into an Eskimo family and brought up with the Eskimo family. In this case he would have a perfectly good Eskimo conscience which would be quite different from that of his Presbyterian family. This throws some doubt on this whole question of conscience. So, when looking objectively at conscience we find that all conscience is, is whatever we believed before we were six years old. If anybody is going to live according to his conscience entirely and give it overriding value over everything else, then he is saying in effect: I knew more before I was six years old than I have ever learned since, and he might just as well if he has anything to decide of importance, go out on the street and ask the first six year old child just what he should do about it, because that is exactly what he is doing and it is just as accidental as that, when he calls upon his conscience.

If we are going to deal with man as we have dealt with the other animals, we must become technical about man himself, and study man as we have studied the flea, on the same basis of objectivity and reality and say to ourselves: What are we like; what is wrong; what should we be like in order to be able to survive and what can we do about it? Actually we don't have to start from scratch. A lot of hardworking people have been studying man objectively as they are able to and yet get along with their own consciences at the same time. The people who have been doing that are the social anthropologists, psychologists, psychiatrists, sociologists and a few other people who belong to other fields. These minds have been working for some years now trying to understand man objectively in terms of reality. They have not gone along very far

in telling anybody what they can do about it, but it is coming! Here and there voices are being raised to question accepted modes of behavior in relation to man's reality.

One might say of people 100 years ago that they could be mature in satisfactory terms for their time and place and still be unable to get along in comfortable ways in all kinds of places with a great many kinds of people. They weren't in contact with many kinds of people. That has changed. It now requires an ability on the part of all people to get along with all people, for this is a very little world, and we live now with all kinds of people through the media of newspapers and radios every day. We are up against their behavior at our breakfast table; and the last thing we hear on the radio as we go to sleep is the behavior of some queer people who may live in some other part of the world.

It is not possible to see our own local problems except in the context of the world. It is not possible to understand what is going on in our own little community, our own backyard unless we see it in context with communities—what is going on in all other places. What happens in one town affects the lives of people all over the world. What happens in one country is reported within 24 hours in the newspapers and radios of other countries all over the world. The picture that our backyard shows is the material on which we are judged, and on which our opinions are quoted by other peoples of the world.

The basic need that every child has is for uncritical love—not on any altruistic basis, because it is not just a question of wanting; it is a question of needing so that he is able to get on with his development. If the child finds this unquestioning, uncritical love completely, his world is a "reasonable" one. He learns that the universe is friendly. He learns that people are "nice". He learns that he is liked and he doesn't have to be afraid to like other people. He doesn't have to be afraid of exposing his emotions. He doesn't have to go about with a chip on his shoulder. He doesn't have to demand that other people come three-quarters of the way towards him. He doesn't have a lot of suspicions that the world is potentially dangerous or surrounded by enemies—that everyone is trying to get the better of him—that they are not friends but hate him. This is not to say that these results are necessarily permanent or unchangeable. They can be changed, but only with great difficulty and with considerable personality distortion. A child needs love first, and he can begin to explore in relation to other people; but the original premise that people are "nice"—that people primarily like him sticks with him.

The child will meet exceptions, but they will be experienced as exceptions by him. He will find that wherever he goes because he is basically a friendly person; he will take for granted good will and he will find it. He may make friends with all the children on the street. He makes friends with the postman and with everyone with whom he comes in contact and he doesn't dislike them because of their religion, or their color or their political conviction. He still thinks they may be "nice" people even though they may be black or pink or any other color. If on the other hand he is developing hostility with suspicion, then any difference from himself, he takes for granted conceals some aspect of antagonism—all his own hates, frustrations and antagonisms are projected on the other person and he will see it everywhere where it does not exist. And he will react towards other people not the way they are, but the way he sees them.

To reach maturity he must feel in his personal relations a friendly atmosphere and a child should be able to regard all the people in his whole community in a friendly way. He should be able to experience from their point of view. He should be able to understand that, although their methods of living, their ideals, their political attitudes, their religion are not quite the same as his own, they are really nice and intelligent people.

As he goes on, he may reach maturity on a national level. This requires an equal degree of concern for the welfare of all the kinds of people, independent of race, religion, education, political ideas or any other differences. Only through that stage is it possible for him to attain maturity on a world level, as is now required for the world in its present state of de-

velopment. *The whole structure, the whole phenomenon of the United Nations, presumes the availability of mature people all over the world.* What faces us, is whether they exist or whether they can be brought into existence soon enough, in enough places to enable the United Nations and all its agencies to survive and function efficiently. One hopes there are enough people sufficiently mature in enough places to help enough other people to become mature soon enough to be able to face fact and reality. This is not easy. It is very painful to recognize that our primary necessity is to prevent our children from growing up the way we have been and are. We are the kind of people who have been fighting each other for centuries. We are the kind of people who have a feeling for power, for our ability to force decisions on some other kinds of people. That method of thinking is as obsolete as a dodo. If we impose these methods on our children, literally and in the most factual terms, we also kill our children. We do just that. We destroy the race. We must change our whole attitude. We must recognize and suspect everything we ever believed—not that everything we ever believed was necessarily incorrect or untrue. But how do we know which ones are true and which ones are not true unless we think about them? We are not entitled to take on faith anything from anybody about anything because our ancestors have never met with this kind of world. Nobody has. We have to find a method of living in *this* world. We must change the original premises of our thinking. The time has gone for that other kind of thinking. There is the painful necessity for us to begin to think for ourselves. And it is indeed painful. Yet, if we face the reality about man, we find that the only thing man has that is better than the other animals, is this thinking capacity. *Man's only demonstrable superiority is his brain.* Man's destiny depends upon his use of his specialized equipment. Anything that prevents man using his brain for himself is a sin against man's destiny and will work for his destruction.

And that is the problem. If enough of us in enough places will think for ourselves and help our children develop an ability to think for themselves, then we may be able to set up a world in which the race can survive. To borrow a phrase from Abraham Lincoln, this may well be our last best chance on earth!

World Health Organization

CANCER FILMS AVAILABLE

Three professional 16 mm films have been made available by the American Cancer Society for showings before physicians and nurses.

One is entitled *A Problem of Early Diagnosis* and runs for 30 minutes. It is in color and highlights the fact that the family doctor holds the key to reduction of cancer mortality. It shows the remarkable progress made in the last 50 years in surgical and radiologic treatment methods and reveals through animation the ways in which lives can be saved by early diagnosis and treatment.

The second is entitled *Breast Cancer, The Problem of Early Diagnosis:* It is also in color and runs for 30 minutes. It is the second of the series and was produced by the American Cancer Society and the National Cancer Institute, and the U. S. Public Health Service.

The third film is for nurses and runs for 25 minutes. It is in color and emphasizes special role of nurses in early diagnosis and in the rehabilitation of patients, who have undergone treatment.

These films may be obtained on loan without cost from the American Cancer Society (New Jersey Division) 790 Broad Street, Newark 2, New Jersey.

TRICHINOSIS WITH MYOCARDIAL AND PULMONARY INVOLVEMENT*

A CASE REPORT

Harold H. Goldberg, M.D., Newark, N. J., and David Biber, M.D., Union, N. J.

Trichinella spiralis infestation varies from region to region in the United States. Its average prevalence has been estimated at 20 percent, including those without clinical manifestations. Mortality in epidemics ranges from one to 30 per cent. In sporadic cases, it is under 5 per cent.

Most cases give rise to a mild systemic reaction, but the clinical picture depends primarily on what tissues or organs are invaded. The gastrointestinal tract, the musculature, the nervous, respiratory, cardiovascular system and the skin may be involved, as well as the kidneys and organs of special sense. When the heart is invaded, as apparently occurred in this case, findings may include dyspnea, orthopnea, and cyanosis. Congestive failure occasionally supervenes. A systolic murmur is usually heard at the apex.

The myocarditis is caused by the presence of the larvae in the myocardium. They produce an inflammatory reaction. The pathogenesis of the pneumonia may be on an allergic basis and thus be allied to Loeffler's migratory pulmonic infiltration with eosinophilia. Our patient had both myocardial and pulmonary involvement, and had an unusually severe clinical course.

A 23-year-old housewife was admitted to Beth Israel Hospital on March 1, complaining of fever, pain in the chest and difficulty in breathing. Her illness had begun about three weeks previously with fever, diarrhea, peri-orbital edema, and muscle pains. She had eaten raw pork on many occasions prior to her illness: she was very fond of this food. She was hospitalized elsewhere for the following two weeks and was discharged much improved. During this period her eosinophile count ranged from 15 to 20 per cent. Stool examinations revealed no parasites, and an intradermal test with trichinella antigen was negative.

She was home but three days when she very abruptly developed anorexia, dyspnea, and chest pain again. Further hospitalization was advised.

On admission to Beth Israel Hospital she appeared toxic and very dyspneic. A soft systolic murmur was heard over the apex. There was dulness over the right lower lobe and diffuse tenderness over the entire abdomen. It was felt that she probably had trichinemia and that there was involvement of the diaphragm and myocardium.

The hospital course was stormy. Intercostal involvement was so marked that respirations became very labored. Cyanosis developed soon after admission and the patient remained for two weeks in an oxygen tent. Attempts to remove her from the tent earlier than that proved premature, for she immediately showed cyanosis and labored breathing. Complaints during this period included

Figure 1

headache, severe muscle pains, and intercostal pains. The temperature was 105 at first. Defervescence was gradual, taking four weeks to reach normal.

Therapy was symptomatic and supportive. Oxygen, blood transfusions, sedatives and vitamin supplements were given.

The laboratory data included an intradermal test with trichinella antigen, which was positive. Later the complement fixation for trichinosis was reported positive. Leukocyte counts fluctuated from 8000 to 12,000. Red cells varied from 4 to 4.5 million with hemoglobin in proportion. Six eosinophile counts ranged from 10 to 25 per cent. Muscle biopsy was negative.

Stool was negative for parasites as was the blood smear and sputum. A blood culture was sterile. Pleural fluid was negative for acid-fast bacilli on smear and culture and no parasites were found in it.

X-ray of the lungs taken on the second day

* From the Department of Medicine, Newark (N. J.) Beth Israel Hospital.

showed some pneumonic infiltration at the left base. (Fig. 1). Subsequent films showed varying amounts of pneumonic infiltration and effusion. The process appeared to be maximum in the film taken April 3. (Fig. 2). Both the effusion and pneumonic process appeared to clear gradually, although a small amount of effusion was still present at the time of her discharge on April 18.

Electrocadiograms showed a low T in Lead 1 and inverted T waves in Lead 2 and in the chest leads. (Fig 3).

She was seen for a follow-up examination on May 18. At that time she appeared to be in good

Figure 2

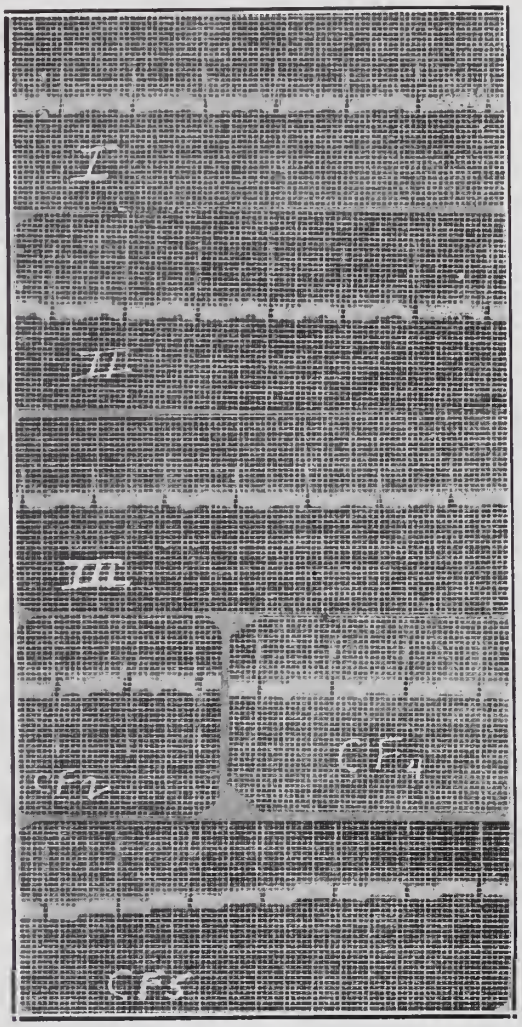

Figure 3

health although she complained of fatigue and some chest pain, particularly on the right. Fluoroscopy showed fixation of the left diaphragm and a right pleural effusion. The electrocardiagram had reverted to normal. (Fig. 4). Eosinophile count was 9 per cent.

The pleural shadow was seen to diminish on subsequent monthly examinations. Fluoroscopy of the chest on November 18, showed both lung fields to be clear. Both diaphragms moved freely. However, on deep inspiration the left diaphragm was seen to be adherent in the left axillary line. The patient was clinically well and has remained well since,—a period of 17 months since discharge.

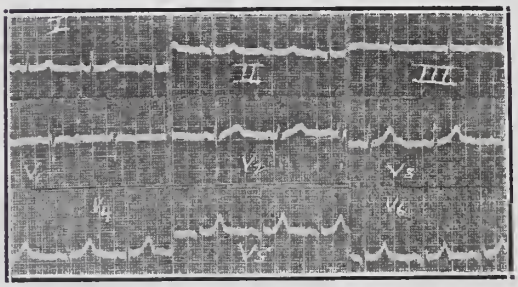

Figure 4

814 South Tenth Street, Newark

900 Stuyvesant Avenue, Union

RECENT ADVANCES IN THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS *

George N. J. Sommer, Jr., M.D., Trenton, N. J.

Discussion of advances in the surgical treatment of pulmonary tuberculosis must be limited by the time available. I will review the most important changes in standard methods, which have occurred during the past several years. The relationship of streptomycin therapy to surgical treatment will be included. The results of certain of these methods applied to patients of the Donnelly Memorial Hospitals and carried out at the St. Francis Hospital will be cited. It is hoped that the introduction of data from small but carefully followed groups of patients may add interest to and clarify the topics discussed.

The surgical treatment of pulmonary tuberculosis has been advanced tremendously by increasing knowledge regarding fluid balance and blood replacement. White and Buxton[22] have demonstrated the considerable blood loss which occurs in thoracic operations including extrapleural thoracoplasty. Routine blood transfusions during operations on the chest have decreased the hazards and simplified postoperative care.

Anesthetic technic has advanced greatly in the past ten years with a more general use of endotracheal administration. The endotracheal tube makes possible frequent aspiration of the bronchi to remove secretions. Moody[9] has developed an endotracheal tube with an inflatable cuff, which can be firmly fixed in the bronchus. With this tube (which is introduced under direct vision through a bronchoscope) a lung or lobe to be resected may be blocked off from the rest of the respiratory tract. A further advantage of the Moody tube is provision for aspiration of secretions through a fine suction tube incorporated in it. The "face-down" postion during operation has again been advanced to prevent the passage of secretions from the lung being treated to the healthy one.

Streptomycin has provided one of the great advances in tuberculosis therapy of our times. Its most important limitation is the development of resistance by the tubercle bacillus to the drug. Muschenheim *et al.*[12] have shown that resistance usually develops within 42 days. During this period of effectiveness, however, streptomycin exerts a powerful repressive action on tuberculous lesions and renders the sputum relatively free of tubercle bacilli. Streptomycin does not replace collapse therapy and should not be substituted for it when collapse therapy alone will suffice. O'Connor[13] has nicely summarized the problem of the relationship of collapse and resection therapy to streptomycin. Acute hemolateral or contralateral lesions may require streptomycin before surgical treatment. Such cases must be properly evaluated prior to the institution of the use of the antibiotic drug, and the entire combined therapeutic regime outlined. Once begun, the combined course of therapy should be carried through and not abandoned because of seemingly favorable results with the antibiotic segment of the therapeutic attack.

In the 1948 "Report to the Council"[14] (based upon work in the Veterans Administration) it was stated that prophylactic use of streptomycin before and during operation for thoracoplasty patients reduced the incidence of spreads of disease from 5.6 per cent in the untreated cases to 2 per cent in the treated. The mortality rate in the treated cases was 3.1 per cent and in the untreated 4 per cent. It was recommended that streptomycin be reserved in standard risk cases for treatment of complications as they arose. The very favorable results of pulmonary resection with streptomycin given prophylactically are beyond question. In 144 pneumonectomies and lobectomies for tuberculosis, spreads of disease occurred in four cases (2.8 per cent). Six deaths occurred (4.2 per cent). Whenever possible patients should come to thoracoplasty and pulmonary resection without being resistant to strepto-

* From the Donnelly Memorial and St. Francis Hospitals. Presented at the 43rd Annual Meeting of the New Jersey Tuberculosis League, Trenton, October 18, 1949.

mycin given without due care and thought to the future.

There is currently a great realization of the dangers of artificial pneumothorax in the treatment of pulmonary tuberculosis. With attention to the contra-indications, however, pneumothorax may be carried on without great danger. It should not be used in patients with tuberculous pneumonia or extensive acute exudative disease, nor in tuberculous bronchitis, with chronic productive disease and large cavities, nor in the presence of emphysema and cardiac disease. With less extensive lesions and relatively fresh disease, excellent results without serious complications may be attained. Streptomycin just prior to induction of pneumothorax may make this treatment safe for some patients with acute exudative tuberculosis. Adequate anatomic collapse is a requirement for satisfactory pneumothorax therapy. Sinding-Larsen[20] showed statistically the difference in results attained with good and poor anatomic collapse. Pneumothoraces should be promptly abandoned in the face of poor collapse and the persistence of pleural effusion.

Brantigan[2] and Hayes[7] have recently advised that thoracoscopy with closed intrapleural pneumonolysis be carried out, when necessary, promptly after the induction of pneumothorax. Brantigan[2] has performed thoracoscopy less than five days after induction. He pointed out the difficulties in performing early pneumonolysis from lack of hospital beds or a place on the operative schedule. The value of early operation is not generally realized by physicians.

Since 1946 early thoracoscopy has been practiced at the Donnelly Memorial Hospital. The operation has usually been carried out as soon as possible after the third week of pneumothorax and sometimes sooner. Bronchoscopic examination has preceded thoracoscopy since an unsuspected tuberculous bronchitis causes atelectasis after pneumonolysis. Thoracoscopy has been performed 91 times in 64 patients. In five cases thoracoscopy was bilateral. Multiple operations bring the total to 91. The shortest time interval was ten days from the induction of pneumothorax to thoracoscopy, which was accompanied by complete pneumonolysis in three such cases. Average time interval before thoracoscopy was 32 days in 69 instances. If two cases, in which no adhesions were found are eliminated, the average time interval was 29 days. In these two cases thoracoscopy was performed 110 and 123 days, respectively, after induction of pneumothorax. Complete pneumonolysis was attained in 34 cases (49.3 per cent). No technical advantages were seen in delaying thoracoscopy. Pneumonolysis was not easier in several patients from other sources whose pneumothoraces were of much longer duration prior to operation.

The complications of early thoracoscopy and pneumonolysis were not severe. Hemorrhage from a fine vessel in an adhesion divided near the left subclavian artery required an open thoracotomy for ligation of the vessel. In twelve instances (17.4 per cent) pleural effusion developed some months after pneumonolysis. One case of empyema, manifested by demonstration of tubercle bacilli in clear fluid, occurred. The policy of prompt abandonment of pneumothoraces unsatisfactory anatomically and of those with pleural effusion prevented the development of serious complications.

CASE ONE

A 19 year old white woman was admitted with bilateral pulmonary tuberculosis October 1, 1948 (Fig. 1). Tubercle bacilli were demonstrated in the sputum by direct smear. A right pneumothorax was induced November 29. Roentgenographic examination December 3, (Fig. 2) showed the right lung suspended by apical adhesions. After bronchoscopic examination, right thoracoscopy was carried out Dec. 9; complete pneumonolysis was accomplished with the division of several cord and string adhesions. Left pneumothorax was induced January 24, 1949. On February 7 roentgenographic examination (Fig. 3) showed the left lung suspended superiorly by adhesions. Left thoracoscopy with complete pneumonolysis was carried out February 8. Recovery from both operations was uneventful. Sputum and gastric contents have been examined by smear and culture on a number of occasions without demonstration of tubercle bacilli. The patient is now at home. Roentgenographic examination October 7, 1949 (Fig. 4) shows bilateral selective collapse. The two successful pneumonolyses were accomplished 10 and 15 days, respectively, after induction of pneumothorax.

Renewed interest in extrapleural pneumonolysis arose with the report of Wilson,[24] who used lucite ball plombage. Trent, Moody, and

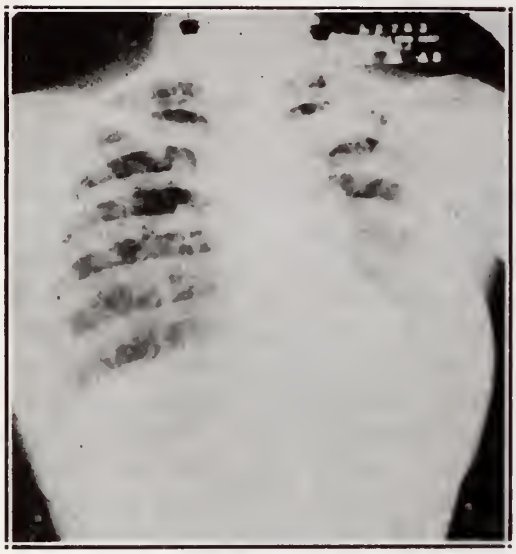

Fig. 1. Case 1. Roentgenogram showing bilateral far advanced pulmonary tuberculosis (Oct. 1, 1948).

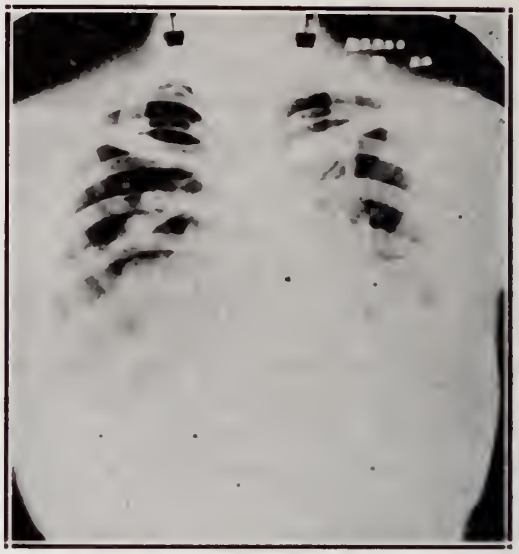

Fig. 3. Case 1. Roentgenogram with bilateral pneumothorax; left lung suspended by viscero-parietal adhesions (Feb. 7, 1949).

Fig. 2. Case 1. Roentgenogram with right pneumothorax and lung suspended by viscero-parietal adhesions (Dec. 3, 1948).

Fig. 4. Case 1. Roentgenograms showing bilateral selective pneumothorax (Oct. 7, 1949).

Hiatt[22] have shown that the late results attained at the Duke Hospital with extrapleural pneumonolysis with lucite plombage have been far from satisfactory. They do not recommend further use of this procedure. I feel that there is a definite place for extrapleural pneumonolysis with paraffin plombage for small apical cavernous tuberculous lesions especially when such lesions are bilateral. Steele[21] has reported excellent results with paraffin plombage in such cases. A comparison of the illustrations of Wilson[24] and Steele[21] shows that Wilson[24] used his procedure for much more extensive lesions than did Steele.[21] While it seems probable that paraffin is a more suitable filling substance than lucite balls, Steele's

superior results are more likely due to a better selection of patients with limited lesions. In all, Steele had 61 per cent of his patients with sputum and gastric contents negative for tubercle bacilli, while Trent, Moody, and Hiatt[22] reported only 24 per cent improved. The last authors are to be thanked for making a proper report of unfavorable results. It is hardly necessary to state that extrapleural pneumonolysis is not a substitute for thoracoplasty, but is an operation to be used when pneumothorax has failed and thoracoplasty is for some reason contra-indicated. It is important to emphasize that paraffin plombage should not be used for extensive lesions. Steele limits the paraffin to 250 Grams.

Since extrapleural thoracoplasty is an established and well standardized permanent collapse method, the discussion will be limited to the use of streptomycin with thoracoplasty in a series of 43 cases. In general, the recommendations of the "Report to the Council"[14] have been followed.

Streptomycin was given four patients (9.3 per cent) some time prior to operation to control acute tuberculosis lesions. In five additional patients, streptomycin was started just before the first stage operation and continued during the course of the operations. Three spreads of the disease occurred during operation in untreated patients; all three spreads were controlled by streptomycin and the operations were successfully completed in two. Nine thoracoplasties were carried out in the presence of contralateral pneumothorax (20.9 per cent). There has been one postoperative death (2.3 per cent). In all, 117 stages were performed giving an operation mortality rate of 0.76 per cent. Follow-up data are not complete but reports available on cultures of sputum and of fasting gastric contents indicate that more than 75 per cent of the entire group are negative for tubercule bacilli. In two patients pneumonectomy was successfully carried out because of persistent cavities in the lung collapsed by thoracoplasty.

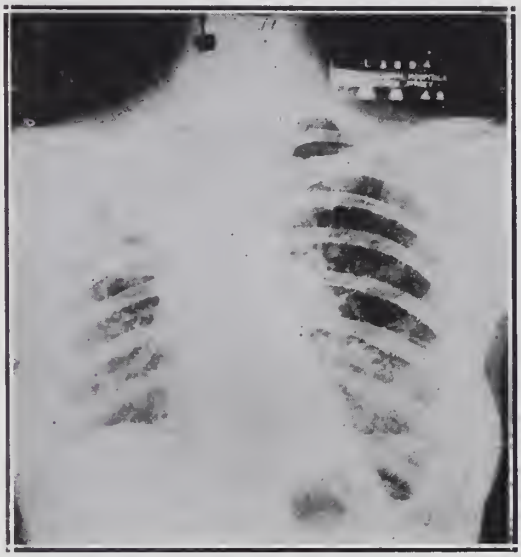

Fig. 5, Case 2. Roentgenogram showing dense upper lobe tuberculosis with cavity and acute exudative lesions below (June 3, 1949).

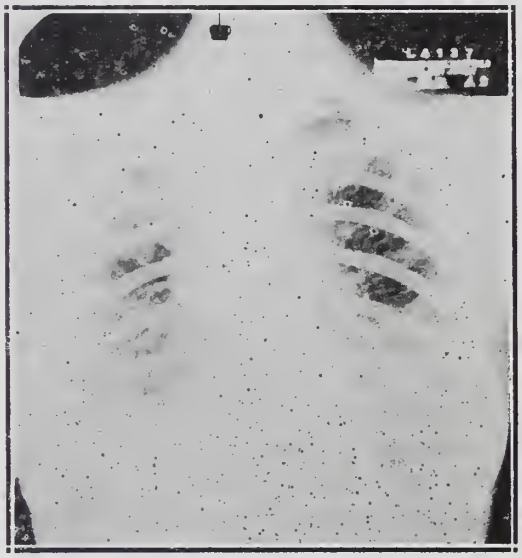

Fig. 6, Case 2. Roentgenograms showing improvement in exudative lesions with streptomycin therapy (July 25, 1949).

CASE TWO

A 37 year old white female, was admitted June 2, 1949. Tubercle bacilli were present in the sputum on direct smear examination. Roentgenographic examination June 3, (Fig. 5) showed a dense infiltration with a large central cavity in the right upper lobe with acute tuberculous lesions below. Bronchoscopic examination found edema of the mucous membrane about the upper lobe orifice. Streptomycin therapy, one Gram daily, was commenced July 3, and continued until August 19. Roentgenographic examination July 25, (Fig. 6) showed marked improvement in the acute lesions. First stage thoracoplasty was performed July 26, and the three stage, seven rib thoracoplasty was

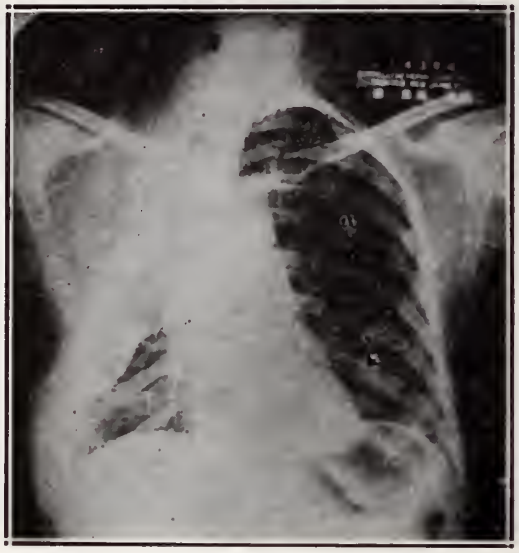

Fig. 7, Case 2. Roentgenogram following seven rib thoracoplasty (Sept. 26, 1949).

completed September 8. Roentgenographic examination September 26, 1949, shows the completed thoracoplasty. Three cultures of fasting gastric contents have since been negative for tubercle bacilli.

Pulmonary resection is now recognized as a proper measure in the treatment of pulmonary tuberculosis. The generally accepted indications for resection are bronchial stenosis, bronchiectasis with tuberculosis, large tension cavities, lower lobe cavities with remaining lobes clear, thoracoplasty failure, and tuberculomata. Shaw[19] states that the late results may be disappointing due to the tendency of other lesions in the lung to break down. Post-pneumonectomy thoracoplasty is used to prevent over distention of the remaining lobes and lung. Iverson and Skinner[8] have recently proposed doing the thoracoplasty at the same time as the pneumonectomy. Although I fear that postoperative paradoxical movement would probably be a dangerous problem, Iverson and Skinner[8] have apparently had no such difficulty in their seven cases. They state the advantages of the combined operation to be: prompt obliteration of the pleural space, single procedure, avoidance of mediastinal shift after operation, and an effective coughing mechanism.

The operative mortality rate for pulmonary resection for tuberculosis has reached reasonable levels especially when combined with streptomycin therapy. It may well be feared, however, that an increasing number of patients may be presented for resection when already streptomycin fast. Bailey, Glover, and O'Neil[1] have demonstrated considerable improvement in two consecutive series of 100 patients, each, undergoing operation without and with streptomycin therapy. Moore, Murphy, and Elrod[10] reported an operative mortality rate of 8 per cent in 74 cases. The collected group of the "Report to the Council",[14] as mentioned, had a mortality rate of 4.2 per cent in 144 cases. There were no deaths following 22 resections for tuberculomata reported by Sellors and Hickey[18] and by Shaw.[19]

Chamberlain[3,4] has recently proposed segmental pulmonary resection for tuberculosis. The operation should be chosen for properly selected, well isolated and walled off single lesions. In a series of some fifty patients there have been four deaths. In Chamberlain's experience the operation is more difficult than lobectomy for tuberculosis and than segmental resection for nontuberculous lesions. Postoperative residual air pockets and bronchial fistulae are more frequent than after total lobectomy. Chamberlain[4] feels that segmental resection should be carried out only by experienced thoracic surgeons and that meticulous postoperative care is necessary to attain good results. Further experience and follow-up studies are necessary to properly evaluate segmental resection for pulmonary tuberculosis.

CASE THREE

A 46 year old white woman, was admitted by transfer January 17, 1947. She had suffered with tuberculosis since 1927 and had spent most of that time in sanatoria. A permanent left phrenic nerve paralysis had been performed. Roentgenographic examination January 27, (Fig. 8) showed a clear right lung; the left lung was shrunken and dense with a "Swiss-cheese" appearance; the left hemidiaphragm was markedly elevated. Tubercle bacilli were demonstrated in the sputum after a number of examinations. Bronchograms showed the left lung to be totally bronchiectatic. A left pneumonectomy was carried out October 30, 1947. Streptomycin, one Gram daily, had been begun October 23, 1947, one week prior to operation, and was continued until December 2. Two Grams of streptomycin were placed in the pleural cavity before closure of the

Fig. 8. Case 3. Roentgenogram showing chronic tuberculous lesion of left upper lobe and markedly elevated left hemidiaphragm (Jan. 27, 1949).

Fig. 9. Case 3. Roentgenogram following left pneumonectomy (July 13, 1949).

thoracic wall and several times afterwards. The patient has been discharged. Sputum has been absent since operation. Cultures of the fasting gastric contents have failed to demonstrate tubercle bacilli. Roentgenographic examination July 13, 1949, (Fig. 9) shows the late postoperative condition.

Empyema with bronchial fistula has long been regarded as one of the most dangerous complications of pulmonary tuberculosis. Sarot and Gilbert[15,16] and Sarot[17] pursued a radical approach to this problem by combining total excision of the pleura with pulmonary resection. Either pneumonectomy or lobectomy was used as proper in the individual case. These operations probably represent the only satisfactory approach in some otherwise hopeless cases. They do not replace extrapleural and Schede thoracoplasty in properly selected cases. Experience with nontuberculous empyema has shown that in very chronic cases the separation of the parietal and visceral scars can be carried out only with the greatest difficulty. It should be pointed out that the cases of Sarot and Gilbert had relatively fresh tuberculosis.

Pulmonary decortication has been proposed by Mulvihill,[11] Gurd,[6] and others in the treatment of nonexpendable lung after pneumothorax and empyema. In my opinion, best results will be attained in relatively early cases without infiltration of the lung parenchyma by the pleural scar tissue. Furthermore, Gordon and Welles[5] and Wright *et al.*[25] have shown that the function of the decorticated lung may be disappointing. The poor respiratory function of the decorticated lung does not detract from the desirability of obliterating the pleural space by this method.

SUMMARY

A number of advances in the surgical treatment of pulmonary tuberculosis have been reviewed. Surgical procedures, in general, are being carried out with improved results and with low mortality and morbidity rates. Furthermore, they are being used earlier in the course of disease than was thought proper in the past. Streptomycin is a powerful adjuvant for the surgical treatment of tuberculosis. It must be carefully evaluated in advance, and a therapeutic plan formed with regard to streptomycin and surgical therapy. Great care should be exercised in employing streptomycin in cases which may later require thoracoplasty or resection.

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A bibliographic list of 25 citations appears in the author's reprints.

RECURRENT APHTHOUS STOMATITIS TREATED WITH AUREOMYCIN

Max Braitman, M.D., West New York, N. J.

Recurrent herpes simplex is a problem which often plagues physician and patient alike. Chronicity, tendency to recurrence, unusual locations, discomfort and resistance to treatment characterize this affliction. In the mouth, it is more commonly known as aphthous stomatitis—a painful annoying symptom-complex, affecting the mucous membrane of the cheeks, gums and tongue; the lips and the nose. The attacks may occur at regular intervals, of varying frequency, duration and severity; one attack may run into another. The herpes simplex virus is responsible. The attack may be precipitated by some trigger factor, such as foods, "nervous tension", foci of infection, sun, wind or the menstrual period. Often no precipitating factor can be found.

Various treatments have been used, all with fair to no success. These include multiple small-pox vaccinations, moccasin snake venom and x-ray therapy.

Recurrent herpes simplex stomatitis is, as a rule, even less responsive to routine therapy. In an effort to provide relief to a patient, aureomycin was given as illustrated by the following case.

A 32 year old female with chronic recurrent persistent herpes simplex stomatitis, was first seen in 1947. She had had outbreaks for five years, characterized by the presence of 5 to 7 painful lesions in the mouth at all times. Cheeks and gums were the usual sites, tongue occasionally. In all five years, she had never been free of attacks. Numerous dental treatments and diet restrictions had had no effect. She was given a course of six small-pox vaccinations, and later, penicillin tablets, plus local therapy—all without effect.

In March 1949, she suffered marked discomfort from a particularly severe attack, in which eating and talking were painful. She was given eight capsules of aureomycin (250 milligrams each) and told arbitrarily to take one in the morning and one in the afternoon. Within two days, pain had ceased; within four days, the lesions had vanished. For the next six weeks, she was free of all attacks—for the first time in seven years. With recurrence, only one or two lesions appeared. These were of short duration. The attacks were fewer. After a few weeks' wait, to appraise the character of the new outbreaks, she was given aureomycin again—two capsules a day for sixteen days. The lesions continued to appear during this interval, but were of the newer variety. The last dose of aureomycin was in May 1949. Occasional lesions appeared over the summer months, one to two a month and of short duration. Since August, no lesions have appeared. At the time of this writing,* the patient has remained symptom free. What will happen in the next year is conjectural, but to date the patient is pleased.

Reports on the use of aureomycin in herpes simplex involvement of the mouth have appeared by Baer and Miller,[1] Fischer and Schwartz,[2] and Distelheim and Sulzberger.[3] All these have emphasized the excellent results obtained from the use of aureomycin.

Several other cases of chronic recurrent herpes simplex of other areas of the body are at present under treatment. From preliminary observation, the results are encouraging. Certainly aureomycin should be used in chronic recurrent herpes simplex infection.

412 Sixtieth Street

* December 15, 1949.

1. Baer, R. L., and Miller, O. B.: Journal of Investigative Dermatology, 13:5 (July 1949).
2. Fischer, A. A., and Schwartz, S.: Journal of Investigative Dermatology, 13:51 (August 1949).
3. Distelheim, I. H., and Sulzberger, M. B.: Journal of Investigative Dermatology, 13:115 (September 1949).

DICUMAROL † IN THE TREATMENT OF HEART DISEASE COMPLICATED BY PREGNANCY *

HARRY M. SCHNEIDER, M.D.,* Jersey City, N. J.

The use of dicumarol † in the prevention of explosive vascular episodes during pregnancy has been frowned upon more from theoretical or apparent complicating dangers than from known clinical phenomena. Mendelson[1] cites the case of a pregnant woman who had been treated for 51 days with dicumarol † because of antepartum thrombophlebitis. No details are given concerning levels, nor is the method of prothrombin determination described. The baby died *in utero* and was found to have massive mediastinal hemorrhage "not accounted for except by dicumarol † administered to the mother antepartum".

The fetus in animals appears to be injured in several ways by dicumarolization of the mother early in pregnancy. Kraus, *et al.*[2] in a study of rabbits, concluded that "dicumarol † treatment is not advisable in a pregnant woman, since it may seriously interfere with the normal development of the fetus or cause fetal death". The prothrombin level of the infant was affected to a much greater extent than that of the mother. Even when "safe" prothrombin levels were maintained in the mother, the infant rabbits revealed an extreme decrease of prothrombin at birth, with a definite hemorrhagic tendency. The mother, however, did not experience excessive intrapartum or postpartum hemorrhage.

The opportunity has recently presented itself on the obstetrical service of Dr. J. F. Norton to observe a well controlled problem of this nature. A case of rheumatic heart disease evolved in its natural course in such a manner, that dicumarolization was deemed a life saving measure for mother and offspring. As pregnancy progressed, response to dicumarol † was so dramatic and satisfying that it was considered advisable and important to continue this therapy through the pregnancy, labor, delivery, and postpartum period.

CASE REPORT

This was a 34-year old, gravida-7, para-4 patient admitted to the Margaret Hague Maternity Hospital on November 5, 1948. Last menstrual period had been on May 26, and the expected delivery date was March 2, 1949. From the age of fourteen to the age of twenty-six, she had had "rheumatism" every winter, both knees being involved with swelling, pain, redness and heat. There had been no medical care, the patient usually staying in bed a few days with each illness. In 1937, during the fourth pregnancy, she was hospitalized in her sixth month because of exertional dyspnea, and was told that she had heart disease.

I saw her in the cardiac clinic of the Margaret Hague Maternity Hospital during her sixth pregnancy in 1944. At that time, prior to pregnancy, she had had one flight dyspnea and two-pillow orthopnea, with some decrease in cardiac reserve during the pregnancy. At eighteen weeks, cardiac dullness extended 2 centimeters outside the midclavicular line. A long loud rumbling diastolic murmur with presystolic crescendo was heard over the apex. A somewhat roughened long systolic apical murmur was also present. The diagnosis was rheumatic heart disease, enlarged heart, M.I. M.S. R.S.R. Class *II*. At 26 weeks she delivered a 740 gram living, premature boy, who died eighteen hours after birth, with atelectasis at both bases.

In June 1946, she was suddenly awakened one night by a "heart attack" with marked dyspnea and orthopnea. She sat up straight in bed and coughed up a few tablespoons of frank blood. Digitalization was instituted by her family doctor. From then on she noticed hemoptysis of varying degrees following exertion. This occurred "every now and then" up to the time of the last pregnancy.

From the onset of the pregnancy there was a progressive increase in shortness of breath. In view of her past history, when the patient came to the Margaret Hague Maternity Hospital Clinic in her 19th week (on October 15, 1948) immediate hospitalization was advised. This was not done though, until November 5, 1948, when she appeared at the Clinic and was found to have orthopnea and dyspnea, and a pulse of 110. She was at once admitted to the Hospital. She gave me the history of having avoided exertion prior to pregnancy, because of dyspnea and orthopnea, also of sleeping on three pillows. Her dyspnea and orthopnea had increased during the pregnancy. Some coughing had been present for the past week, and leg edema, when "on her feet a while", was relieved overnight. She was in moderate distress, sitting straight up in bed. Pulse was 130 and respirations were 36; blood pressure was 110/78. The heart was enlarged to the left with systolic, diastolic, and presystolic mur-

† Dicumarol is the registered trademark of the Wisconsin Alumni Research Foundation which controls the use thereof.

* From the obstetrical service of Dr. J. F. Norton at the Margaret Hague Maternity Hospital, Jersey City, N. J. Dr. Schneider is Assistant Cardiologist to the Margaret Hague Hospital.

murs at the apex, transmitted over the precordium. P2 was louder than A2. Regular sinus rhythm was present. Pulse and apical rate were 130. Medium and fine rales were heard at the bases more on the right. No neck vein distention was noted. The liver and spleen were not palpable. She had no edema. Diagnosis was "rheumatic heart disease, enlarged heart, M.I. M.S. R.S.R. congestive heart failure, Class IV E, Class *III* D, prior to pregnancy, pregnancy 22 weeks". Because of the apparent progress (far along in the natural course of her disease) her age, previous and present failure, and functional classification of the heart, prognosis was considered very guarded. She was placed in an oxygen tent and digoxin was given to the point of tolerance. Mercuhydrin, milk and water diet, and morphine were used. Oxygen had to be administered constantly for 72 hours after admission, and then (intermittently) for 72 hours more.

On November 21, pulse and apical rate were 80, the chest was clear, the heart was compensated and medication was changed from digoxin to digitoxin. She was told to remain in bed for the remainder of her pregnancy. On November 22, after breakfast, she had a brief episode of substernal oppression with increased expectoration, slightly blood tinged. Pulse was 90 and regular. A few dry crackles were heard at both bases. On November 23, transient rales were heard at both bases, the pulse and apical rate were 104. The patient was considered to be in borderline failure, and more vigorous therapy was instituted with frequent weighing, mercurials and increased dosage of digitalis. The course was then improved with pulse varying between 74 and 98.

On January 12, 1949, some hemoptysis was noted in the morning. She coughed a great deal and at 10:30 a. m. produced blood tinged mucus. At 11 a. m. she brought up a half tablespoon of bright red stained mucus. At 5:30 p. m. she was coughing mouthfuls of bright red blood mixed with occasional brownish sputum. The patient was very apprehensive. Medium rales were heard at the right base, and a few at the left base. She complained of tightness over the sternum. The diagnosis was "Probable pulmonary infarction on the basis of pulmonary congestion or embolic phenomenon". Codein, phenobarbital, aminophyllin and mercuhydrin were given. Digitalis dosage was increased, and the head of the bed was raised 9 inches. The use of dicumarol,† in spite of apparent dangers, was considered. The next day, hemoptysis recurred, and the patient complained of a dull ache in the back, about the mid-lumbar level. Pulse and apical rate were 108 and regular, respirations 20, lungs clear, right upper quadrant tender to palpation. Dicumarol† was then started and continued, as indicated by the figure.

Thereafter the entire course of the patient's illness changed. No further hemoptysis occurred. The patient stayed on strict bed rest, and "head up" position was maintained for several weeks. Venous pressure and circulation times were normal on January 29 and on February 21. The heart remained apparently well compensated, with definite improvement, as expected[3] in the ninth month. Six foot film of the chest, on February 22, revealed marked prominence of the middle segment on the left side of the cardiac silhouette.

On March 12, 1949, at 7:45 a. m. the membranes ruptured and mild, irregular contractions occurred every seven to ten minutes. At that time, blood pressure was 110/60. The chest was clear, and there was no edema and no neck vein distention. The liver was not palpable. Pulse was 96 and prothrombin level was 25 per cent. Labor began at noon, and at 3:11 p. m. a normal, 3040 gram female infant was born under open drop ether anesthesia, the second stage being expedited with Tucker-McLain elective low forceps. The placenta followed at 3:15 p. m., and at that time the maternal prothrombin level was 21 per cent. Cord blood and blood from the infant also were taken for prothrombin level. Ergotrate was then given intravenously. Total blood loss was estimated at 250 cubic centimeters. Throughout the entire procedure the patient showed no signs of respiratory or cardiac distress. Pulse varied between 96 and 100, respirations 18 to 20 at 15 minute intervals. The patient was placed in an oxygen tent postpartum to help repay any oxygen debt incurred during labor, although she showed no signs or symptoms indicating the need. One hour postpartum the pulse and apical rate were 82, color satisfactory, no dyspnea, no evidence of cardiac distress, condition entirely satisfactory. The oxygen tent was removed after 3½ hours, and from that time on the course was very smooth. Dicumarol† regime was continued until the patient was ready for discharge. No dicumarol† was given after the seventh day postpartum, as the level remained within desired limits. No excess bleeding was noted throughout the puerperium. The venous pressure on the 11th postpartum day was 5.9 centimeters with a rise on right upper quadrant pressure to 10.2, this being considered to mean that there was some hepatic congestion at the time. The arm-to-tongue decholin time was 12½ seconds. The patient was allowed up on the 11th day and discharged on the 17th postpartum day, after fluoroscopy of the heart. The marked prominence of the left middle segment on postero-anterior view on x-ray was found to be made up principally of pulmonary artery. Barium in the esophagus revealed narrowing and backward bowing in the region of the left auricle in the right anterior oblique position. Discharge diagnosis was the same as that at the onset of the pregnancy, namely, RHD. EII. MI. MS. RSR. *III* D. CHF. Blood count, chemistry, platelet count, blood coagulation time, and clot retraction, were all normal at the time of discharge.

Progress of the infant. At birth the infant's appearance and measurements were normal. Cord blood measured less than 4 per cent prothrombin level with femoral vein blood hemolyzed. Not enough blood could be drawn thereafter for prothrombin levels, and so bleeding and clotting times were followed. Seven hours after delivery, bleeding time was three minutes, clotting time sixteen minutes five seconds. At eighteen hours, bleeding time was two minutes and clotting time twenty minutes forty-five seconds. At thirty hours, bleeding time

was three minutes twenty seconds, and clotting time over thirty-five minutes. At that time the infant was pale. The areas of previous needle puncture swelled with hematoma and the baby looked slightly jaundiced. The blood count was 3.18 million red cells, 80 per cent hemoglobin, and 2 polychromatic normablasts per 100 white cells. We then gave 65 cubic centimeters of blood intravenously plus hykinone 4.8 milligrams every four hours for sixteen doses, with an immediate desired response. The next morning bleeding time was one minute forty-five seconds, and clotting time five minutes forty-five seconds, and red count 3.35 million. The rise in the red count continued up to 4.6 million on March 18, after which it again dropped gradually, with no noticeable clinical change in the infant, to 3.21 million on March 29.

In the clinic on April 28, the baby was normal in every respect with a red count of 3.92 million, hemoglobin at 11.3 Grams, color index, 1.0, white count 7900.

The measurements and weights may be seen in the accompanying table, and indicate progress as would be expected in a healthy infant.

COMMENT

The patient was on dicumarol† for eight weeks antepartum, maintained at good therapeutic levels, then throughout labor and delivery and postpartum with no complications therefrom, with excellent therapeutic and prophylactic results. Dicumarol† postpartum had been shown by Barnes and Ervin[4] to cause no increased bleeding. Possible harmful effects to the fetus were postulated by Kraus and others,[2] from animal studies. Here then is a case with increased clotting tendencies due to three and possibly four factors, namely, enforced bed rest over a long period of time, chronic heart failure with infarction resulting from emboli from mural thrombi or from thrombosis initiated by marked slowing of blood circulating in the pulmonary circuit, pregnancy, and possibly the use of digitalis.[5] Dicumarol† was then deemed essential for the life of the mother and child, and was proved to be so without permanent harmful effect. The maternal response was ideal in every way while the status of the infant was somewhat precarious and indicated the need for vitamin K immediately on delivery.

CONCLUSION

A case of severe rheumatic heart disease, complicated by pregnancy, is presented. The patient needed the therapeutic and prophylactic effect of dicumarol† to help bring her through pregnancy and puerperium successfully. At the same time, it is shown that dicumarol† need not be injurious to mother or child when given in pregnancy and parturition, nor to the mother when given postpartum.

TABLE ABSTRACTED FROM DAILY DETERMINATION OF PROTHROMBIN PER CENT AND ADMINISTRATION OF DICUMAROL †

Date 1949		Prothrombin per cent	Dicumarol† milligrams
January	13	100	200
"	17	54	150
"	21	26	...
"	22	20	...
"	26	40	100
"	29	32	50
February	3	25	..
"	7	40	100
"	11	29	50
"	15	36	100
"	20	27	100
"	23	25	...
"	27	38	100
"	28	30	...
March	6	30	...
"	7	36	...
"	8	26	50
"	9	26	100
"	10	37	100
"	11	29	...
"	12*	25	...
"	12	21	
"	13	25	...
"	14	34	50
"	15	53	100
"	16	51	100
"	17	100	100
"	18	29	...
"	19	34	100
"	20	26	...
"	21	21	...
"	22	21	...
"	23	29	...
"	24	29	...

* March 12 was the date of delivery.

Measurements of Infant, born on March 12.

1949	Length cms	Head cms	Chest cms	Weight Grams
March 12	51	35	32	3040
March 15	..	..	..	2980
March 17	..	..	..	3060
March 25	..	..	..	3040
March 29	52	36	34	3140
April 28	55	..	..	4090

89 Gifford Avenue

The citations appear in the author's reprints.

THE COUGH-PAIN SIGN IN ACUTE SUPERFICIAL THROMBOPHLEBITIS

Elias D. Lawrence,* M.D., Paterson, N. J.

Acute superficial thrombophlebitis usually occurs in the presence of varicose veins. However, cases are seen without varicosities. Symptoms range from a slight discomfort to increasing tenderness, pain, swelling, redness, edema and rise in temperature. These patients are unable to work. Disability may vary from a few days to seven or eight weeks, depending on the extent of the inflammatory process and the effectiveness of the treatment. Unfortunately, recurrences are common.

The purpose of this paper is to present a simple test that has proved useful in evaluating superficial thrombophlebitis, and that has been helpful in decreasing disability by indicating the proper treatment.

Standard treatment technics generally stress rest in bed, elevation of the affected part, application of heat and the use of antibiotics. End-results are hard to appraise, since adequate follow-up studies are rare. However, one fact does stand out: most of the patients are confined to bed. This is contrary to the principles accepted for the prevention of thrombosis in veins and arteries. In fact, stasis, plus an existing insult to the vein wall in the form of thrombosis (plus, possibly, a low grade infection) favors propagation of the thrombus. This is the last thing one desires in these cases. Any surgeon who has explored the greater saphenous vein after prolonged bed rest will attest to the presence of "silent" thrombus in a high proportion of cases. The relationship of bed-rest to phlebothrombosis has been well established. Any treatment that will decrease the discomfort and disability and also keep these patients ambulatory should prove of value.

Patients with acute superficial thrombophlebitis of the legs have more discomfort when standing. This is due to the pressure of the column of blood above with distention of the inflamed vein. I have noticed that in many cases the pain in the inflamed area was increased by coughing, sneezing, or laughing. In these cases, compression of the greater saphenous vein close to the saphenofemoral junction resulted in the disappearance of the pain on coughing. This was found to be present in practically all patients who were seen early or when the area involved was at the knee or proximal; and in about 50 per cent of the cases with involvement below the knee. I have called this the "cough-pain sign". When positive, it is interpreted to mean that there is an insufficiency at the saphenofemoral junction or at the site of a communicating vein, transmitting an impulse down the saphenous vein and causing pain by distending the inflamed vein. The logical treatment, therefore, is to ligate the saphenous vein at the saphenofemoral junction or at the site of the communicating vein. This has been done in 24 cases, and the results were uniformly good. All patients had immediate relief of the fulness, heaviness, and severe pain that existed previously on standing. All patients were made ambulatory at once. The local tenderness and redness at the site of the phlebitis rapidly subsided. Whatever discomfort persisted was easily controlled by acetyl salicylic acid with or without codeine. Women were able to do light housework in from five to fourteen days, and men returned to regular work within two weeks. All patients remained ambulatory. This ligation in superficial thrombophlebitis has been reported in the literature by others[1] with the same favorable results.

Not all cases of superficial thrombophlebitis give a positive "cough-pain sign". The sign may be absent if the inflammatory process is subsiding or if involvement is below the knee. In these cases (regardless of the presence or absence of varicose veins) if there is a reflux of blood at the saphenofemoral junction elicited by any test but especially the cough impulse test of Adams, then ligation is definitely

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1. Heyerdale, W. W. *et al.*: Proceedings of the Staff Meetings of the Mayo Clinic, 18:1. (January 13, 1943).

indicated.[2] If no "cough-pain sign" is present, but if the pain in the involved area is aggravated by standing, or if the inflammatory process spreads upwards, then ligation is indicated.

I have seen one case of acute superficial thrombophlebitis of varicosities of the greater saphenous vein at the knee with a positive "cough-pain sign" that remained positive even after compressing the saphenofemoral junction. After further study, a large communicating vein was found five inches above the knee. On compressing this vein with the finger, the "cough-pain sign" disappeared. A saphenofemoral ligation plus a supplemental ligation at the site of the communicating vein gave prompt relief in this case.

Thrombosis of the greater saphenous vein may extend up to the saphenofemoral junction without symptoms. These cases must be handled carefully to prevent pulmonary embolism. A positive Adams cough impulse test means an insufficiency at the saphenofemoral junction and is an indication for a ligation operation. The incision parallels the pubic crease over the site of the impulse, and the vein is exposed carefully, noting the presence or absence of thrombosis. If a half inch of the proximal greater saphenous vein is free of thrombus, it is dissected carefully and two curved Kelly clamps are applied. The vein is cut between clamps. The upper end is dissected upwards, ligating and cutting all branches, exposing its junction with the femoral vein. It is ligated with silk close to the femoral. A second transfixion silk suture is applied. The lower end of the vein is dissected downwards, opened, and the clot expressed. A thrombus may be found to extend up to the saphenofemoral junction, and it is possible gently to compress the clot down sufficiently to apply a curved Kelly clamp to the upper end of the vein. This is not advocated unless the surgeon has sufficient experience in recognizing the existing condition and in coping with it. Where the thrombus fills the entire saphenous vein (and possibly protrudes into the femoral vein) great care must be used. A piece of silk is placed around the saphenous vein about one centimeter from the junction, and another placed about five centimeters distally. The vein is incised lengthwise between these silk supporting sutures, the thrombus grasped carefully with an Allis or Babcock clamp, and (after releasing the proximal silk suture) gentle traction usually results in the thrombus gliding out of the vein from above downwards. A gush of blood signifies a clear vein, and traction on the silk controls the flow of blood until a curved Kelly clamp can be applied. Where organization of the thrombus has already started, it is difficult to remove the clot. The vein should be then ligated and cut. The surgeon must then use his judgment whether to explore the common femoral or the iliac vein or the inferior vena cava and ligate them, or resort to heparin and/or dicumarol.†

The following case illustrates how extensive the thrombosis may be without symptoms and the value of the "cough-pain sign":

A male patient, age 53, with moderate varicose veins developed pain on the inner aspect of the upper calf of the left leg. There was no fever, but the area became red, hot, and very painful. He was treated with bed-rest, elevation of the leg, hot packs, and 300,000 units of penicillin daily. The acute inflammatory process cleared up slowly. On the ninth day he was allowed out of bed and that night he developed pain and swelling just above the knee of the same leg. The following day it had spread to the mid-thigh. On that evening, I first saw the patient and found a positive "cough-pain sign" and a positive Adams cough test. The groin was free of inflammatory involvement. Ligation at the saphenofemoral junction was performed the next morning. At operation, the saphenous vein was found thrombosed up to the saphenofemoral junction. The thrombus was freely movable in the vein. After careful dissection, the vein was freed from surrounding tissues, and compressed between the thumb and index finger, displacing the thrombus distally so that a curved Kelly clamp could be placed close to the junction with the femoral vein. The vein below was then opened, the clot expressed, and the vein tied with silk. Five centimeters of the vein were excised. The upper clamp was removed after tying and transfixing with silk. The patient was ambulatory at once and sent home. He made a prompt, uneventful recovery. The acute inflammatory process subsided within 36 hours, the acute pain disappeared almost at once, and the patient returned to work on the 14th day.

2. Lawrence, Elias D.: Journal of the International College of Surgeons, 9:3 (June 1946).

† Dicumarol is the registered collective trademark of the Wisconsin Alumni Research Foundation which controls the use thereof.

Another group of cases to be considered are those with thrombophlebitis already involving the groin due to rapid spread or failure to respond to the bed-rest and heat treatment. The "cough-pain sign" is of no value here. These patients must be kept in bed and given heparin and/or dicumarol† to prevent propagation of the thrombus into the deep veins of the leg, the iliac vein, pelvic veins and the inferior vena cava.

SUMMARY

The author presents a simple test that has proved valuable in indicating the need for the ligation operation in superficial thrombophlebitis of the legs. Ambulation is important to prevent extension of the thrombosis. Prompt relief of symptoms and regression of the inflammatory process occurred in all cases treated. A case is presented illustrating the use of the "cough-pain sign" in indicating the need for early ligation.

499 Park Avenue

AVULSION OF THE LOWER BICEPS BRACHII TENDON

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Avulsion of the lower biceps brachii tendon is rare. Dobbie[1] reported two cases and gave an excellent analysis of 51 previously unreported and 24 previously cited cases. Since then, additional cases have been reported by several other observers.[2]

This is a report of an additional case and a short review of the subject with particular regard to the operative treatment.

The biceps brachii tendon inserts into the rough posterior portion of the tuberosity of the radius. It is a flexor of the elbow and to a less extent, of the shoulder. It is also a powerful supinator and serves to render tense the deep fascia of the forearm by means of the lacertus fibrosus given off from its tendon.

The brachialis fibers converge to a thick tendon which is inserted into the tuberosity of the ulna and the rough depression on the anterior surface of the coronoid process. The brachialis is a flexor of the forearm and forms an important defense of the elbow joint. When the forearm is fixed, the biceps brachii and brachialis flex the arm upon the forearm, as in efforts of climbing.

Flexion of the elbow by the biceps is more important than its function as a supinator as the action of the biceps is not essential for supination.

Following avulsion, reinsertion of the biceps tendon into the radial tubercle is theoretically the proper procedure. Practically, function is equally as good following insertion of the tendon into the ulna, either directly or indirectly, as into the tendon of the brachialis.

The important structures besides the muscles mentioned found in the antecubital fossa are the brachial artery and vein, radial and ulnar arteries, median and radial nerves and of course the tendon of the biceps brachii. It is because of these important structures found in this region the type of repair recommended by Dobbie was followed in this case.

Dobbie's conclusions in his series were as follows:

1. Avulsion of the lower tendon of the biceps brachii from its insertion into the bicipital tuberosity of the radius, though uncommon, is not as rare as is suggested by the few recorded case reports.
2. The history of injury, subjective symptoms and objective signs are constant and diagnostic.
3. The lesion is disabling and requires operative repair.
4. Repair of this condition when unexpectedly encountered for the first time is a perplexing problem to the surgeon because of his desire to restore supination as well as flexion power. Loss in power of the forearm flexion is the outstanding disability and the chief objective of operative repair should be its restoration. The supinative power of the biceps is of secondary importance and can be ignored for when it is lost, it is adequately compensated for by the muscles of the forearm.
5. Direct reattachment of the tendon to the upper radius is difficult to accomplish, time consuming and not without danger.
6. Other methods of repair less difficult and dangerous are equally effective and reported end results justify their use.

1. Dobbie, R. P.: American Journal of Surgery, 51:662 (March 1941).
2. Sharpe, W. E.: American Journal of Surgery; 54:733 (December 1941); Hamsa, W. R.: Nebraska Medical Journal, 27:140 (April 1942), and Hook(6) and Sakaguchi(8) cited below.

TYPES OF REPAIRS

Rogers[3] uses braided silk through drill holes, in the radial tubercle.

Baumann[4] ties the end of catgut sutures over a gauze pad on the back of the forearm. He too, used holes through the radius.

Leavitt and Clements[5] through drill holes, brought the tendon to the radial tuberosity. They say that "although the inconvenience of the working space did not make for the satisfaction desired with the reinsertion, it apparently was adequate".

Hook and Mazet[6] remark on the relative ease with which they were able to expose the radial insertion. This, they credit to the shortness of time between injury and repair; leaving visible the canal leading to the insertion and at its end the tuberosity was palpable.

Bunnell[7] uses a pull out wire suture *via* a drill hole through the tuberosity.

Sakaguchi[8] reported a case sutured by wire *via* drill holes. Two months later the wire was removed and found to be broken. The danger of this wire injuring nearby structures was noted.

Steindler[9] mentions overlapping the tendon and suturing it to itself via a drill hole through the radius.

Sonnenschein raises a trap door in the radius and places the end of the tendon therein.

Other methods were reported by Dobbie,[1] including nails, fascia and ox tendon.

CASE REPORT

On May 16, 1949, this 54-year old male was lifting a storm door. His right hand was under the door which weighed fifty pounds. As he started to raise the door, he suddenly felt as though he had torn his shirt. He had no pain, but reported a transitory feeling of numbness of the hand. He took off his jacket to see if his shirt was torn and noticed "his muscle was up near his shoulder" and "a hollow space where the muscle was".

He was a well built, muscular, right handed man. His only complaint was the "peculiar appearance" of the right arm. The biceps brachii muscle was displaced proximally. A hollow was present in the area normally occupied by the biceps muscle. Motion of the arm was normal. Both supination and pronation compared well with the left arm. Extension was normal with normal power. Flexion was full with marked loss of power.

He was admitted to the Fitkin Memorial Hospital, Neptune, N. J. Operative repair was done the same day.

A curved skin incision was made over the ventral aspect of the elbow. The median basilic vein was ligated, the cephalic vein was retracted. The biceps tendon was found curled on itself, lying in the space between the pronator teres and the brachio-radialis muscles. The distal end of the tendon was bulbous, frayed and dark red. Some old blood was found in the fossa. During the dissection, the nerves in the antecubital fossa were retracted. The main large arteries were seen pulsating and avoided.

Repair of the tendon was done as recommended by Dobbie[1] although I modified it somewhat. Thus, I did not divide the tendon before suturing it to the brachialis. No attempt was made to reinsert the tendon onto the radial tubercle. Instead, I attached it to the tendon of the brachialis as it dipped down toward the ulna. Interrupted cotton sutures were used to join the tendons together. Additional sutures were then inserted, joining the biceps tendon to the fascia of the brachialis muscle just proximal to its tendon. The distal one-half inch of the biceps tendon was excised before it was sutured to the brachialis tendon.

The skin wound was closed with interrupted cotton sutures; a compression bandage was used and a posterior plaster splint applied with the arm at 90 degrees flexion and in full supination. Active motion of the fingers was encouraged immediately following operation. Operation was done under sodium pentothal anaesthesia without a tourniquet.

Skin sutures were removed in ten days. The arm showed moderate swelling at this time. The splint was removed in three weeks and a sling substituted. Active motion was started within the limits of the sling. After six weeks the sling was discontinued and light work was encouraged. Motion at this time was normal except for 15 degree loss of extension.

Five months later he was back at his regular work as a plumber. Examination then showed full extension and flexion, full pronation and supination, with only slight loss of power of supination.

SUMMARY

This is a report of avulsion of the distal of the biceps brachii. The types of repair are mentioned and preference given to the type recommended by Dobbie.[1] The final results in all types of repair are good but the technic used in this case can be followed without endangering any important structure.

3. Rogers, S. P.: Journal of Bone and Joint Surgery, 21:197 (January 1939).
4. Baumann, G. I.: Journal of Bone and Joint Surgery, 16:966 (October 1934).
5. Leavitt, D. G., and Clements, J. H.: American Journal of Surgery, 30:83 (October 1935).
6. Hook, F. R., and Mazet, R.: U. S. Navy Medical Bulletin, 40:409 (April 1942).
7. Bunnell, Sterling: *Surgery of the Hand.* Lippincott, Philadelphia, 1948. Second edition, page 586.
8. Sakaguchi, N.: Wisconsin Medical Journal, 46:797 (August 1947).
9. Steindler, D.: *Traumatic Deformities of the Upper Extremities.* Thomas, Springfield, Illinois (1946) Page 195.

94 South Main Street

UNUSUAL REACTIONS WITH ANTABUSE

REPORT OF THREE CASES *

Robert S. Garber, M.D., and Robert E. Bennett, M.D., Trenton, N. J.

Reports are now appearing in the literature of the results of the use of antabuse (tetraethylthiuramidisulphide) in the treatment of alcoholism. This restricted drug has not yet been released for sale to the public. However, a number of centers throughout the country, including this hospital, are working with antabuse on a research basis.

Three untoward reactions have been observed in patients following release from the hospital and it is timely to report them now.

Antabuse was discovered in Denmark by Dr. Jacogsen and Dr. Martensen-Larsen. They were working to develop a drug against certain intestinal worms. As an incidental observation, it was noted that a person taking this drug, upon ingesting alcohol in any form, always developed a particular chain of symptoms which made drinking "impossible". This drug has no effect by itself. After consumption of even small amounts of alcohol (within eight to ten minutes) the following symptoms develop: First, there is flushing of the face and neck, which becomes progressively more marked and, if sufficient alcohol is consumed, becomes a very dusky red color. Pulse rate increases. The patient complains of palpitation and constriction of the chest. A severe headache soon follows and then blood pressure may tend to fall. Dyspnea may become marked. The eyes appear injected and a feeling of tiredness and weakness is present. If sufficient alcohol is consumed, nausea with severe vomiting follows. Actual convulsions have been reported. Thus, the effects of alcohol on a patient taking antabuse are severe. This is especially so with respect to cardiovascular effects. These symptoms are brought about by the reaction of antabuse and alcohol by which acetaldehyde is formed in the blood stream. It is this agent which produces the symptoms.

At this hospital before a patient is placed on antabuse he must express a sincere desire to stop drinking and agree to cooperate for all the studies and tests. Complete physical and laboratory studies are accomplished, including electrocardiograph, six foot chest film, consultation with a cardiologist, electroencephalogram, metabolism test, glucose tolerance tests, liver function tests, kidney function tests, as well as routine blood and urine studies. If all results are within normal limits, then and only then is the patient started on antabuse.

The drug comes in half Gram tablets. Our routine has been to start with four tablets the first day, three the second, two the third, and one and half the fourth day. The patient is then tested with 10 cubic centimeters of whisky. This usually does not produce much of a reaction and the dose is continued at one and half tablets daily. Four days later, the patient is tested with 15 cubic centimeters of whisky. Then, by lowering the daily dose of antabuse and increasing the test dose of whisky by 5 cubic centimeters at a time, we determine the amount of antabuse which, when one ounce of whisky is given, produces a reaction of sufficient severity to impress the patient with the effect that ingestion of alcohol will have. The patient is then released from the hospital but agrees to take antabuse every day. It is essential that the medicine be taken daily in order to maintain an adequate level within the body. The effects of antabuse persist for two weeks following discontinuation of the drug. On leaving the hospital, the patient is given a wallet card summarizing these facts. This is useful if he has a reaction in which his consciousness is impaired and is also helpful if he goes to a physician for treatment of some other condition.

The patient returns to the hospital once a month for retesting, physical examination and laboratory tests. At such time the dose of

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antabuse may be adjusted downward or upward depending upon the severity of the reaction to the test.

The important point, for the practitioner, is that a person taking antabuse *cannot take alcohol in any form.* Tonics, cough medicines and the like which use an alcoholic vehicle would be sufficient to produce an untoward and possibly severe reaction.

Antabuse has been in use at this hospital since June 1949. We have 30 ex-patients now in the community who are taking antabuse. Three of these have had reactions as a result of inadvertently coming upon alcohol in a rather unusual form.

CASE ONE

A male, aged 35, was released from the hospital on September 25, 1949, and was taking 0.25 Grams of antabuse daily. Three weeks following his return, his wife prepared his favorite meal: boiled cabbage and ham with cole slaw. This man was fond of vinegar and the cole slaw was made with a considerable quantity of vinegar. In addition, he splashed vinegar liberally over his ham and cabbage. Twenty minutes after starting the meal he developed flushing of the face, palpitation dyspnea and headache. He recognized the symptoms as an antabuse reaction and by a process of elimination decided that the vinegar must have been responsible. On examination of the gallon jug in which the vinegar was kept it was discovered there was an inch of sediment at the bottom of the jug. Apparently this vinegar had fermented and formed enough alcohol to produce a reaction.

CASE TWO

A male, aged 36, was taking one tablet of antabuse (0.5 Grams) daily. It was his habit, after work, to play handball at his club, take a shower, and then have the trainer give him a rub-down. He noticed that towards the end of the rub-down he would have a slight flushing of the face, palpitation and mild headache. He was sufficiently uncomfortable to request the trainer to discontinue the rub-down. This happened on several occasions. It finally occurred to the patient that rubbing alcohol was being used; he reported these occurrences and was advised to substitute some non-alcoholic rubbing agent. This was done and no further reactions were experienced.

CASE THREE

A male, aged 50, suffered an accident which had no relation to his antabuse. While hospitalized he was receiving massage and back-rubs. On two occasions he developed flushing of the face, palpitation, dizziness and headache. When this was reported, it was discovered that alcohol was being used for the massage. As soon as this was discontinued there were no recurrences.

SUMMARY

Three unusual reactions to alcohol in antabuse patients are reported. No patient receiving antabuse can "touch" alcohol in any form without experiencing a reaction. These cases are of interest to the private practitioner because a fair number of persons now in the community are taking antabuse, and the number is steadily increasing. The physician will be called upon to treat these patients for various conditions. If, in spite of apparently having eliminated all medication containing alcohol the patient still has some of these symptoms, it would appear to be wise to investigate all procedures being used to determine those in which alcohol is inadvertently being applied.

State Hospital, Sullivan Way

THE FAMILY IS THE HEALTH OFFICER

The family is engaged in a variety of activities associated with homemaking, and child care with which we are so familiar that we often fail to realize their significance. If there is to be any effective health care and preventive medicine, it cannot be provided by doctors or nurses—however much their knowledge and skills may be needed by the family. Health care and preventive medicine are carried out in the daily activities of housekeeping and homemaking. Through marketing, cooking and the serving of meals, basic nutritional needs must be met, and through housecleaning, laundering, dishwashing, and similar sanitation, the necessary defense against infections and contamination must be maintained. Through provision of rest, care of minor ills, and all the cherishing functions within the home, individual members are protected and restored, so that they can live in health and carry on their daily activities. Lawrence K. Frank, *The Survey,* Dec., 1949.

CALCIFICATION OF THE PREPATELLAR BURSA

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Calcification of the bursae about the knee, judging from the number of case reports in the literature, is exceedingly rare. Norley and Bickel[1] reviewing the records of the Mayo Clinic could find but eight cases. Calcification about the medial collateral ligament of the knee (described as Pellegrini—Stieda's Disease) is occasionally seen. Brantigan and Voshell[2] are of the opinion that this condition is sometimes the result of calcification of the bursa *beneath* the ligament and not of the ligament itself. A search of several textbooks failed to find any mention of calcification of bursae about the knee by any authority except Mercer[3] who states that in association with gout, degenerative changes sometimes occur in the walls of the bursae and the lumen is distended by chalky deposits.

This is in sharp contrast to the frequency with which one sees calcification of the bursae about the shoulder. This is surprising for if trauma is a factor, the bursae about the knee are certainly subject to as much trauma as those about the shoulder.

Many and variable bursae have been described about the knee joint. Anteriorly are found: (1) the prepatellar, located between the skin anteriorly, and the lower half of the patella and the upper half of the patella ligament posteriorly, (2) the suprapatellar beneath the quadriceps tendon and which usually communicates with the knee joint, (3) the infrapatellar between the upper end of the tibia and the posterior surface of the patellar tendon, and (4) a small one in front of the tibial tubercle. Posteriorly the most frequent ones are between the heads of origin of the gastrocnemius and the capsule and between the medial gastrocnemius origin and the semimembranosus. On the medial side one separates the tendons of the gracilis, semitendinosus and sartorius from the medial collateral ligament and another the ligament from the capsule of the knee. On the lateral side, bursae have been described between the biceps tendon and the external collateral ligament, and about the popliteus tendon.

CASE REPORT

A well developed male in apparent good health came for treatment of pain and tenderness about the right knee. The symptoms had been acute for about 3 weeks. He gave a rather vague history of injury to the knee about 20 years previously at which time the knee was swollen and tender over the front of the patella. The pain and tenderness disappeared in a few weeks but he noticed a slight swelling persisted over the knee cap. It gave him no trouble until the onset of the present attack.

Examination revealed a nodular mass over the lower region of the patella about the size of a small marble. It was moderately tender. Extension of the knee was normal but flexion was limited by a few degrees. There was half inch atrophy of the right thigh at 7 inches above the patella as compared with the left thigh. X-ray examination revealed a normal knee except for calcification of the prepatellar bursa.

The patient was more annoyed than incapacitated by the condition and it is his desire that the mass be removed. Accordingly surgical excision is planned.

TREATMENT

As with calcified bursae about the shoulder, no treatment may be indicated if the condition is asymptomatic. If the condition is painful, injections of 1 per cent novocain may be tried to break up the calcified deposit. This may be supplemented by infra-red or diathermy. If these conservative measures are of no avail, surgical excision is indicated.

SUMMARY

Calcification of the bursae about the knee is rare. A case of calcification of the prepatellar bursa is presented.

950 Park Avenue

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THE STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS

Jacob L. Balk,* Emanuel Klosk, M.D., and Arthur Bernstein, M.D.,
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A competent diagnostic index is a vital adjunct to a progressive medical institution or agency. This recognition is due in no small part to the demonstrated efficiency of the *Standard Nomenclature of Diseases and Operations.*

Medical records as we understand them today are a fairly new development in the history of medicine. Prior to 1915 few hospitals maintained complete descriptive case records. The majority of hospitals recorded only sketchy data, which, in many cases, amounted to no more than identification information.

This situation was brought home very graphically to the medical profession when the American College of Surgeons was formed in 1913. One of the requirements for admission to fellowship was that the surgeon submit detailed records of one hundred operations. The surgeons turned to their hospitals for these data. In most cases they were shocked to discover that the information available was completely inadequate.

To rectify this, the American College of Surgeons established a minimum standard for case records, and made it mandatory that hospitals seeking recognition by that College follow that standard. Primarily as a result of this persuasive action, the maintenance of competent medical records became routine.[1] The next problem was how to handle these data so that the information contained in the charts would be readily available on a selective basis. The expedient which occurred most readily, and was therefore widely adopted, was to index alphabetically the diseases and operations listed on a patient's chart. With few exceptions the indices were set up without reference to any standardized list of diseases; and interns, residents, and staff members had a free hand in their use of terminology. This freedom with terminology coupled with the use of untrained administrative personnel constituted a primary source of difficulty with this primitive system.

In most hospitals the task of making entries in the diagnostic index was delegated to clerks who had had no training in this and who were certainly not equipped to exercise judgment. If the clerk were presented with a diagnosis framed in different words, but covering the same disease, what did he do? He simply started a new subdivision in the index. If several cases of "erythremia" had already been indexed, and a new staff member chose to call the next case "Osler's Disease", the clerk simply started a brand new heading for "Osler's Disease". He did not know that erythremia and Osler's Disease were the same and nobody ever told him. Thus the same condition could be indexed in a half dozen different places. Over the years, with constant changes of personnel, the system led to utter chaos.

Nor was it all the fault of untrained clerks. Medical terminology itself was in a state of confusion. Many diseases had been named in hap-hazard manner with blissful disregard of the fundamental etiologic or pathologic processes involved. Sometimes the same name—Paget's Disease, for example—was applied to two quite different diseases; or the same disease (hyperthyroidism, for instance) had two or three different names.

Even indices which were carefully maintained, with scrupulous effort to avoid terminologic duplication, were found to suffer from basic faults. They did not distinguish between related disease entities; or they did not distinguish between diseases and symptoms; they used eponyms extensively. Identical disease entities were listed under several headings, and the same heading often was used to designate entirely different disease entities. As an illustration, "hyperthyroidism", in addition to being indexed under several descriptive names, was listed in medical indices under the names of nine different men; and "Pick's Disease" was applied indiscriminately to four different diseases which were discovered or described by four different men with the same name.[2]

From the standpoint of scientific methodology, such indices were practically worthless for reseach and comparison purposes. They did not even have the saving grace of being of value to individual institutions, because with every new group of interns and residents, and with every addition of a new staff member, a new series of unscientific terms and eponyms would be added to the indices. In most hospitals, it was actually impossible to make a valid year-to-year comparative study of clinical data.

The situation came to a head in 1928. By this time responsible opinion representing all branches of medicine was unanimous that something should be done to bring order to this phase of medical activity. Under the sponsorship of the New York Academy of Medicine, a committee was organized consisting of eminent physicians, educators, and statisticians. Its purpose was to develop a competent system of indexing capable of universal application.

* Mr. Balk is the record librarian of the Newark Clinical Group. This paper was read before the staff meeting of the Newark Clinical Group on April 22, 1949.

1. Kurtz, D. L.: *Unit Medical Records in Hospital and Clinic.* Columbia University Press, New York City, 1943. Pages 2 to 9.
2. Jordan, E. P.: Journal of the American Medical Association, 121:1001. (March 1, 1943). Also, see Proceedings of the Annual Congress on Medical Education and Licensure, Chicago, February 17, 1941.

After extensive consideration, the Committee established the following principles upon which the new system should be based:

(1) It should consist of a standard classified terminology, with the elimination of as many unnecessary terms and eponyms as could be accomplished.

(2) It should clearly differentiate between disease entities and the manifestations of disease.

(3) As much as possible, it should use only expressive or descriptive terms which best describe the nature of the disease.

(4) It should arrange the diseases in a logical and orderly manner, so that there should be no possibility of overlapping.

(5) It should encourage uniformity and accuracy in clinical expression.

Finally, it had to be broad enough to be capable of universal acceptance, so that the disease files of *all* hospitals could be reciprocally interchangeable, and their clinical experience readily available for study and comparison with the experience of other institutions.[3]

The *Standard Nomenclature of Diseases and Operations* was devised to meet these requirements.

This classification scheme is based on two primary factors: (1) The portion of the body involved (topographic) and (2) The cause of the disease (etiologic). Each of these features is designated by three numerical digits which are separated from each other by a hyphen. The first three digits in the disease code describe the topographic site. The three digits following the hyphen describe the etiologic agent. The digits are uniform throughout the classification, following a single key.

This dual number concept is the most novel feature of the nomenclature. Dr. Edwin P. Jordan,[2] editor of the nomenclature has explained that "the primary purpose of this classification is educational. By clearly differentiating between a disease and its symptoms, and by canalyzing thought along lines of location and etiology, this system tends to improve rational understanding of diseases."

In organizing the structure of the nomenclature, the entire disease field was divided into eleven topographic or anatomic divisions, and twelve etiologic divisions. By drawing three digits from the anatomic classification and combining them with three digits from the etiologic classification, an enormous number of combinations are possible, and any disease can be coded.

The topographic divisions begin with 000-, which stands for diseases of the psyche and body as a whole, and proceed up through the various anatomic systems, such as 300- for respiratory system; 700- for urogenital system; 900- for nervous system; et cetera. These groupings are further subdivided so that particular organs, or parts of organs within the group may be specifically indicated. Thus, 400- designates the cardiovascular system as a whole; 410-designates the heart generally; and 415-designates the right auricle of the heart.

The etiologic divisions are arranged in a similar manner. The major divisions start with -000 for diseases due to prenatal influence, and run through -400 for diseases due to trauma; -800 for new growths; et cetera. Disease processes for which the causes are unknown (and which are manifested by structural changes) are classified under -900. This includes the degenerative and sclerotic diseases. Disease processes for which the causes are unknown and which are manifested by *functional* reactions are classified under -X00. This includes the functional and mental disorders.

The etiologic divisions are also subdivided so that cause may be more precisely indicated. Thus, classification -100 designates "infection" generally. Mycobacterium tuberculosis is listed 23rd, hence -123 indicates infection with the tuberculosis bacillus. Similarly -400 designates trauma generally; -430 indicates that it is a constant trauma; and -434 indicates that it is a constant trauma caused by the abnormal position of anatomic structures.

Most disease entities can be readily indicated by a code number composed of three anatomic digits and three etiologic digits; however, it is possible (by the use of four and five digits) to indicate even the smallest part of an organ, or the most minute etiologic sequence or result.

A cardinal principle of the nomenclature is that the three main values on each side of the code never vary. The anatomic code number for an organ remains the same regardless of

3. National Conference on Medical Nomenclature. Journal of the American Medical Association, 114:2023 and 114:2121 (May 18 and May 25, 1940.)

the causative factor involved, and the code number for a particular etiologic factor remains the same regardless of the organ affected. Thus the ribs are always indicated by code 229- whether fracture, tuberculosis or osteoma is involved. Similarly the effects of a radioactive substance are always coded -470 whether skin, bone, or nerve tissue is affected. Adherence to this principle automatically ensures the recording of a disease under its proper heading regardless of the terminology used in noting the diagnosis.

Surgical procedures are coded in accordance with the basic plan for diseases. The same anatomic classification is used but instead of the etiologic classification there are nine procedural classifications. Thus, -0 indicates incision; -1 excision; -2 amputation, et cetera. By combining these digits with the anatomic code number the exact site and the exact procedure of the operation can be indicated. Here also, by the use of additional digits it is possible to indicate alternative approaches, and special procedures such as aspiration, cauterization, coagulation, snare, et cetera.

The eleven topographic and twelve etiologic systems are supplemented by the system Y00. Y indicates *undetermined* in the sense that there is not sufficient data on which to base a diagnosis, or to complete a diagnosis. If the site of a disease is unknown, Y00- is substituted for the anatomic digits. Thus, a neoplasm of unknown primary site is coded as Y00-800. If the site is known and the etiology unknown, -Y00 is substituted for the three etiologic digits. Thus, an undiagnosed disease of the stomach is coded as 640-Y00. If neither site nor etiology is known, Y00-Y00 is used, indicating disease undiagnosed or diagnosis deferred. Finally, the addition of Y to the end of the code for a known disease indicates that the diagnosis is a possible one, but not definitely confirmed. Thus the code 190-800Y signifies a possible neoplasm of the breast.

The nomenclature contains the code numbers for all diseases and operations, arranged in the numerical order of the anatomic classifications. These codes are integrated with an alphabetical index of every disease and surgical term which has received any extended use, even though it may not be the best descriptive term for the disease or procedure. The index refers all these inadequate terms to the proper name for the disease, and then indicates the exact location in the book where the code number for the disease can be located. There is also an extended list of eponyms which are referred to the proper descriptive name for the disease, and then to the code number.

Although one of the important purposes of the *Standard Nomenclature* is to avoid the confusion of symptoms with disease entities, many diseases do show variations of symptoms and manifestations. It was considered essential that the doctor be able to indicate these variations wherever necessary. To make this possible, the nomenclature carries a list of general symptoms and manifestations, and special manifestations covering cardiac, obstetric, and nervous disease conditions. To each of these symptoms or manifestations an arbitrary code number is assigned, and so, whenever desired, this arbitrary code number can be added to the code of a primary disease, in order to indicate that a special symptom predominates.

To illustrate the applicaion of the nomenclature a hypothetical case is diagnosed as follows:

1. Tuberculosis of the lung.
2. Collapse of lung due to therapeutic pneumothorax.
3. Hypertensive vascular disease.

1. Tuberculosis of the lung is coded as 360-123. The breakdown is as follows: 360 indicates lung, under the anatomic system, and 123 indicates infection by mycobacterium tuberculosis under the etiologic classification.

2. Collapse of lung due to therapeutic pneumothorax is coded as 377-415.4. This offers a striking illustration of the functional precision of the nomenclature, since it indicates how the dual number classification can provide a clearer concept of a disease or procedure than word terminology. Although the condition is spoken of as a "collapse of lung", the anatomic classification of 377 indicates immediately that the thoracic wall and pleura are involved; 415 indicates that the causative factor is trauma resulting from a surgical

procedure; and .4 is an arbitrary indication that a primary manifestation of the entire procedure is compression. To recapitulate: this code might be translated literally as a surgical incision of the thoracic wall and pleura, with resulting compression.

3. Hypertensive vascular disease is coded as 460-533. Breaking down this code, we find that 460 indicates the arteries generally, and that 533 indicates increased pressure. Thus we have a disease of the arteries, due to increased pressure.

For each diagnosis, i. e., each separate disease entity, a master card is carried in the index, and the patient's chart number is entered on the appropiate card. The master card also provides space for the recording by code number of the associated or secondary diagnoses if cross indexing is desired.

The nomenclature is not perfect by any means, and it does contain mistakes, both in the inclusion of improper disease entities and the exclusion of proper ones. Furthermore, the concept of disease is constantly changing, with new knowledge making old disease entities obsolete, and creating new ones. The editorial board of the nomenclature does not consider it sacrosanct, and is constantly making revisions. The intention is to issue a new edition at least every five years. During the intervals, information on any point is obtained by direct communication with the editorial office, which is organized on a permanent basis. The nomenclature is not static; it is a living institution, conceived as a continuing aid to the profession.

While the nomenclature is undoubtedly a most efficient system for the control of medical data, it is not self-functioning, and its value to any institution depends on the degree of understanding and acceptance it receives from the professional and administrative staffs. This brings up a consideration of the practical mechanics of the nomenclature—The problem of how the professional staff and the record librarian can best correlate their efforts so that the diagnostic index will be of optimum value to the physician and a credit to the institution.

There is an impression quite prevalent among physicians that it is the purpose of the nomenclature to force the physician to make a diagnosis before he is ready. It is probable that within any given institution, this misconception increases and intensifies in direct proportion to the competency and conscientiousness of the record librarian. There is no foundation for this impression. Indeed, it runs directly contrary to the philosophy of the nomenclature, which aims to inculcate a disciplined, deliberate and reasoned approach. However, the nomenclature does contemplate that the doctor will give whatever information he does have, so that the case may be indexed within a reasonable time and thereby brought within the controls of the master index. The classification Y was developed for the express purpose of making it possible to record incomplete diagnoses. When etiology is unknown, the site can be given. When site is unknown, the etiology can be given. If neither is known, it can be stated that the disease is undiagnosed, or that diagnosis is deferred. If the management of a case is based on the premise of a possible or suspected diagnosis, the summary sheet should so state. The nomenclature permits the recording in a manageable manner of all these variations. If at some time in the future it becomes possible to give a more definitive diagnosis then the new diagnosis will be entered in place of the old one. That is part of the mechanics of the index.

The quality of a diagnostic index is but a reflection of the care with which its data have been established and assembled. In this process, both physician and record librarian are indispensable. Cooperating with each other they can make the diagnostic index a significant factor in the struggle against disease.

89 Lincoln Park

STATE ACTIVITIES

BOARD OF TRUSTEES

FEBRUARY 19, 1950

The Board of Trustees met in regular session on February 19, 1950, and took the following actions:

1. The Committee on Constitution and By-Laws, in conjunction with the members of the Judicial Council and the attorney of the Society were instructed to draft an amendment to the By-Laws. This would establish a Board to receive complaints from laymen and other sources against physicians in cases involving unprofessional conduct, violation of ethics or any other complaint of professional or public dissatisfaction.

2. It was the feeling of the Board that members who pay their county and state dues should feel obligated to pay their A.M.A. dues. Applications for exemption of payment of A.M.A. dues should not be the responsibility of the county societies but should be directed to the A.M.A. for decision.

3. The Executive Officer was authorized to attend the San Francisco session of the A.M.A. in June.

4. The Executive Officer was authorized to address a joint meeting of the Blue Cross-Blue Shield Commissions in Montreal, this month.

5. The Board approved a study of group life insurance plans by the Medical Defense and Insurance Committee.

6. It was the opinion of the Board that endorsement of serial newspaper articles by individual physicians needs no official action. Sponsorship of such articles is considered a personal project of the individual physician.

7. *Recommended Practices for the Control of Poliomyelitis* were approved (March Journal, page 126).

8. The following statement covering eye examination of school children was approved for reference to the State Department of Education:

1. An adequate vision test should be a part of every school physical examination.
2. The use of the Snellen Chart for distant vision, its equivalent for near vision, properly utilized and supervised, is adequate for testing vision in school children.
3. This should be supplemented by the inspection and observation of the eyes by the school physician.
4. Complicated devices sometimes used in these examinations are unnecessary.
5. Every school system should advocate the preschool eye examination of children.

9. The Board approved the recommendation of the Advisory Committee on Conservation of Vision and Hearing that wherever local problems arise in the school systems, the county medical society should appoint a committee on conservation of vision. Members of that committee should be available to the public schools of the county for consultative purposes in arranging and carrying out a proper school program for eye testing.

10. *The Code of Regulations Concerning Autopsies* was approved. (See page 176 this Journal).

11. Attention was called to the agreement of the Telephone Company with the Medical Society that no listing in the "Physicians and Surgeons" section of the classified directory (and no physicians listed in the regular directory) may be in bold face type. The Trustees instructed the Telephone Company that this agreement does not apply to emergency medical service listings or other collective listings requested by local medical societies themselves; such listings are offered as a public service.

12. The Board concurred in the Legislative Committee's action in opposing, in principle, the proposed legislation to provide supplementary cash benefits of $8.00 per day for hospitalization under the Temporary Disability Benefits Program. To provide additional benefits for special purposes departs from the original intent of the law. A copy of this action will be sent to the New Jersey Hospital Association asking them to concur and to aid our efforts to defeat the proposed extension of the temporary disability benefits program.

13. The Board tabled a recommendation that the federal Food and Drug Administration be requested to restore the original restrictions on the unsupervised use of antihistaminics.

14. The Board concurred in the approval of the bill to control lay clinical pathology laboratories.

15. The Board tabled a recommendation on federal legislation providing subsidy for medical education and school health services and instructed the Legislative Committee to obtain a positive statement from the A.M.A. of its position on these matters.

15. The Board received a report from the Special Committee appointed to meet with representatives of the N. J. Interscholastic Athletic Association regarding alleged inequities in charges for treatment of injured athletes. Study revealed the situation arose because of an attempt on the part of an insurance company to give coverage at an inadequate premium. The report was received and the Committee discharged.

16. Following the report of the President, the New Jersey representative on the A.M.A. Coordinating Committee and the Executive Officer on the complaints against the New Jersey Plan made by the A.M.A. at the February meeting of the A.M.A. Coordinating Committee, the Trustees authorized the drafting of a suitable letter to the A.M.A. Board of Trustees. This reaffirms our endorsement of the New Jersey Plan as issued; explains the points at which issue was raised; and informs the A.M.A. that our President has been authorized to appear before the A.M.A. Board of Trustees to elucidate the points of difference if the A.M.A. so desires.

17. The A.M.A. Delegates from New Jersey were instructed to introduce the New Jersey Plan at the San Francisco meeting in June. Prior to this meeting a copy of the resolution and the Plan will be sent to all A.M.A. Delegates.

18. The Board approved the request of the State Board of Medical Examiners to sponsor an amendment to the Medical Practice Act increasing fines and penalties for violations.

19. The Trustees authorized a plaque in the Headquarters building commemorating the services of Dr. Henry C. Barkhorn to The Medical Society of New Jersey in particular and to the profession and public in general; that subscribers to the memorial fund be notified of the change in location of the plaque; and that the Society underwrite the cost.

20. The Board approved the following nominations for appointment to the State Board of Medical Examiners by the Governor:

1. Listed in order of preference:
   a. Royal A. Schaaf, M.D.
   b. Aldrich C. Crowe, M.D.
   c. Sigurd W. Johnsen, M.D.
2. Listed in order of preference:
   a. David B. Allman, M.D.
   b. Joseph F. Londrigan, M.D.
   c. James F. Norton, M.D.

21. The nomination of Dr. Sigurd W. Johnsen as a member of Medical-Surgical Plan Board of Trustees to fill the vacancy created by the death of Dr. Thomas K. Lewis, was approved.

22. Dr. Royal A. Schaaf, Dr. Reuben L. Sharp and Dr. J. Lawrence Evans were appointed as the General Practitioner Award Committee and directed to select a recipient for 1950 if a sufficient number of good candidates are recommended.

AUTOPSY ADMINISTRATION

The Interrelated Duties of the Hospital Administrator, the Pathologist and the Mortician Concerning the Handling of Patients After Death and the Autopsy*

Prepared by The Advisory Committee on Laboratory Medicine of The Medical Society of New Jersey

CARE OF PATIENTS AFTER DEATH

The body should be cleaned, the feet bound together and the hands bound, folded one over the other, by a broad bandage. The latter must not be so tight as to cause indentations in the skin. Cotton padding or a bandage at elbow height to relieve tension will avoid unsightly marks of the wrists. A bandage passed over the point of the chin and over the vertex of the skull will hold the mouth closed. The head must be kept elevated on a suitable block at all times. So soon as practical after death the body should be placed in a refrigerator, the temperature of which should lie between 40 and 45 degrees Fahrenheit.

The death certificate should be promptly

* Recommendations and regulations mutually agreed upon by The Medical Society of New Jersey, The New Jersey Society of Clinical Pathologists, The New Jersey Hospital Association and The New Jersey Society of Funeral Directors.
Approved by the Welfare Committee, January 22, 1950. Approved by the Board of Trustees, February 19, 1950.

prepared and signed by the proper authority. Each institution is urged to adopt a system whereby the certificate will be available when the mortician calls for the body. Neglect in this regard is one of the greatest sources of irritation for the mortician, and justifiably so. This paragraph applies in cases which have come to autopsy as well as those which will not.

THE AUTOPSY PERMIT

A standard form of autopsy permit should be employed in every hospital, and the signed permit should be filed together with a copy of the report, with the hospital record of the deceased. The permit should show in legible writing (it is a legal document), the full name of the deceased, his age, sex and race, and the date and time of death—indicate E.S.T., E.D.S.T., etc.

It should show that there are no limitations, or that the autopsy is limited to certain areas. It should indicate the clinical diagnosis and the relationship of the person granting permission.

Permission can legally be granted only by the nearest of kin (medical examiner's and county physician's cases excepted). Legal authority should be consulted concerning cases where there are no surviving relatives, almshouse cases, telephoned or telegraphed permission.

The following acts are to be severely condemned:

1. Seeking to obtain permission by misrepresentation of facts in any manner or purposely obtaining a signature without the signer being fully informed as to what he or she is signing.
2. Seeking to obtain permission by threats to turn the case over to the medical examiner or county physician with derogatory implications.
3. Describing the autopsy incision as "a very small incision" at the same time indicating with the fingers a length of about two inches.
4. Extending the autopsy beyond the indicated limitations.

AVOID DELAY

Delay in obtaining autopsied bodies is the second great source of irritation to morticians and again their complaints are frequently justified. The best results are obtained when embalming is performed soon after death. Effective circulation of the embalming fluid is lessened as time elapses. It is recommended that a special effort be made to adhere to the following schedule:

In the case of deaths occurring during the night, the autopsy be completed before noon of the same day.

In the case of deaths occurring during the later morning hours or early afternoon, the autopsy be completed before 6:00 p. m.

In the case of deaths occurring during the late afternoon or early evening, the autopsy be completed that night whenever possible.

If the autopsy is delayed because of difficulty in contacting the family, the mortician might be called upon to give his aid. If the autopsy must be delayed until the day after death, it would be well to permit the mortician to embalm those cases in which the process of embalming would not alter the tissue sufficiently to defeat the purpose of the autopsy.

THE AUTOPSY

The autopsy must be performed by someone trained in making postmortem examinations or under the immediate supervision of someone so trained, and not delegated to those untrained.

The Autopsy Incisions: In the male, the incision may extend from the suprasternal notch to the pubes. The incision should not be carried into the neck unless special permission is obtained, and the embalmer and relatives are fully aware of the difficulty encountered in masking such an incision. In the case of females, children or sailors who may be prepared for public viewing, the incisions should extend from the acromial ends of both clavicles to the xyphoid process and from this point to the pubes. Incisions of the extremities must be made with due regard of the circulation. Incision of the scalp for the removal of the brain should extend from a point over one mastoid process to the opposite side passing over the vertex far enough posterior so that the line of incision will be invisible when the body is prepared for viewing. When the hair is long as in the case of females or children, the hair should be parted along the line of the incision with a comb and the knife should be inserted under the skin with the cutting edge uppermost and the skin incised from beneath outward. In this manner one may avoid cutting the hair.

The saw cut is made customarily from a point slightly above and anterior to the ear around through the frontal area to the opposite side and posteriorly through the occipital bone to the opposite side. The lines of the cut should not be parallel or in the same plane but the posterior cut should form a slight angle with the plane of the anterior cut. This technic will aid in keeping the calvarium in place. The anterior cut should lie behind the hair line if there is a normal distribution of hair.

After removal of the brain, the foramen magnum should be plugged with a tight-fitting cork, the stumps of the vertebral and in-

ternal carotid arteries should be ligated. (This step is not as difficult as it seems.) The cavity should be sponged dry. The calvarium should be anchored in place either by sewing the severed stumps of the temporal muscles or by driving a double pointed upholsterer's tack through the calvarium and the base of the skull at the apex of the saw cut above and in front of the ear on each side. The driving of these tacks is easily accomplished if two holes are drilled through the bone at appropriate distances with a fine drill.

The line of the saw cut in the frontal bone should be smoothed and the severed periosteum freed of folds and wrinkles. If one is careful the line of the saw cut will not be visible when the skinflap is replaced.

Ligation of the Great Vessels: The innominate, the left common carotid and the left subclavian arteries, should be severed at their origin at the aorta and firmly ligated. The common iliacs should be similarly ligated and the ligatures left long so that the embalmer may easily pick them up. Great care should be exercised in handling the vessels in the neck, they are frequently easily torn and then the stumps retract high into the neck, so that it is almost impossible to recover them for injection.

FURTHER RESTORATION OF THE BODY

The law requires that the organs be returned to the body. This frequently presents a problem for the embalmer. It is recommended that each institution prepare suitably sized gauze bags. The organs may be placed in one of these and at the time of embalming the embalmer need only remove the bag as a whole and immerse it in a jar of formaldehyde. Body cavities should be sponged dry. The primary incision should be neatly and tightly sutured so that it does not leak. The body should be washed free of all blood or other stains resulting from the autopsy.

COOPERATION OF THE MORTICIAN

These recommendations also must recognize certain cooperative measures on the part of the mortician.

A reasonable amount of time for the performance of an autopsy must be granted. The time of death and the peculiar circumstances surrounding each case must be considered. The difficulty of contacting the nearest of kin for permission must be recognized and in this the mortician can frequently expedite matters by aiding in this respect. The autopsy is performed for the purpose of disclosing valuable information to the attending physicians, and their younger associates. To be effective, such an investigation must be performed at a time when all of those concerned can be gathered together. Sympathetic understanding will reveal that the delay is not the result of indifference.

The following are to be severely condemned:

Attempting to prevent the hospital authorities from obtaining permission for an autopsy by describing it as gruesome, mutilating procedure, or to tell the family that satisfactory embalming is impossible after an autopsy or to charge an extra fee or threaten to do so if an autopsy is performed.

The Advisory Committee on Laboratory Medicine and the New Jersey Society of Clinical Pathologists will be glad to receive suggestions from morticians or from hospital administrators aimed at lessening the difficulties which surround the performance of autopsies.

Since copies of these recommendations were circulated numerous additional suggestions and corrections were submitted. They do not change the spirit of the regulations but are worthy of special comment.

1. Dr. Braunstein of Hudson County suggests that the autopsy permit should indicate that the person giving permission is responsible for the burial of the deceased. No doubt the significance of this statement becomes apparent only when some hospitals have had difficulty in the disposition of the body of the deceased.

2. In the restoration of the body it is to be desired that the blood vessel continuity be preserved in the best possible state for embalming. The procedure to be followed in the restoration of the skull has been variable. Many pathologists prefer filling the base of the skull with plaster of paris. This is an effective method of plugging the severed vessels at the base of the skull but is objected to by many embalmers, for a variety of reasons. It is a little more tedious to follow the plan mentioned in the recommendations and so far as the Advisory Committee knows there are no objections to this method

RADIOLOGISTS PROTEST OUR HOSPITAL EDITORIAL

In the January JOURNAL we had an editorial entitled "Hospitals and Free Enterprise". The burden of our comment was that the medical profession and the hospital interests were both anxious to preserve our free pattern of medical care, and therefore we ought to be working on the same team. We deplored the fact that, at this crucial stage in our history, efforts were being made to divert our energies into a fight against the hospital interests of the country. The editorial closed with these words: ". . . at a moment when we need all our friends, we have started to raise questions about the good faith of one of our closest allies—the hospital. This is *not* a call for compromise on any of our principles about corporate practice of medicine. It is, however, a suggestion, that perhaps an armistice within the medical family might best serve our common needs today."

In a letter dated February 27, the executive secretary of the American College of Radiology, writes to us to express disagreement with the editorial. Mr. Stronach fears that we were suggesting "further concessions to the hospital interests". The letter follows:

Your editorial begins, "Every once in a while, some medical writer makes the announcement that the organized profession has two battles to fight, not one. Federally controlled medicine is one foe, and hospital practice of medicine is the second."

Later you state, "All of this is but a roundabout way of raising a question. Have the hospitals of the country teamed up with the medical societies? If not, is it the fault of the hospitals? Or is it because, that at a moment when we need all our friends, we have started to raise questions about the good faith of one of our closest allies—the hospital? This is not a call for compromise on any of our principles about corporate practice of medicine. It is, however, a suggestion that perhaps an armistice within the medical family might best serve our common needs today."

In presuming to answer your editorial questions, I should like to ask a few. Is your editorialist aware of the results of the wholehearted acceptance and support of Soviet Russia by this country during World War II? Is he aware of the fact that in Great Britain the Liberal Party exterminated itself by making concessions in joining an alliance with the Labor Party? Does he know exactly what happened to the German industrialists after they lent active support to national socialism? Has he observed what has happened to the Democratic Party in this country when it adopted as a working platform the philosophies of its own left wing?

One would think that there were ample examples of what happens to those who offer bait to gain allies. Formalized ivory tower sitting in regard to the problem of the corporate practice of medicine will certainly lead to further concessions in this regard to hospital interests. If radiology, pathology, and anesthesiology can be accepted as a part of hospital service, there is no reason why many other medical procedures such as appendectomies, tonsillectomies, and obstetrical procedures cannot be so considered. Hospital spokesmen have ever remained on the offensive in the matter of extending the scope of the meaning of "hospital service"; medicine's defense must be adamant if medicine is to survive.

The naive and trusting have not fared too well in this world of late. I believe that the medical profession does well to question the faith of groups wishing to ally themselves with medicine. If the interest of two groups lies in the same direction, they will inevitably pursue the same courses without formal concessions being offered from one to the other.

With best wishes, I am,

Very truly yours,

WILLIAM C. STRONACH
Executive Secretary
AMERICAN COLLEGE OF RADIOLOGY

SCREENING FOR CHRONIC DISEASES

It is increasingly clear that screening the general population for tuberculosis must be combined and coordinated with screening programs for other important conditions—such as cardio-vascular disease, cancer, syphilis, and diabetes—similarly characterized by relatively long subclinical periods in which detection may be life conserving or important to community protection. James E. Perkins, M.D. — 1950 Bulletin of the National Tuberculosis Assn.

SUPPLEMENTARY LIST No. 1 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Assante, M. Hugo, 120 White Horse P.,Clementon(4)
Berry, Leonard M., 205 Nassau st., Princeton (11)
Brophy, Francis X., 55 Gifford av., Jersey City (9)
Brown, Edith L., 340 Garfield av., Avon (13)
Brown, Francis J., 326 Richmond av., Pt. Pleas't(15)
Browning, William, III, Navy (4)
Cavalli, Ralph D., 702 Broadway, Camden (4)
Cetta, Peter, 109 Mountainside av., Nutley (9)
Chesnick, R. B., Grad. Hosp., Univ. Pa., Phila., Pa.(4)
Clement, John B., 178 W. State st., Trenton (11)
Cooper, Jules, 723 Washington st., Woodbine (5)
Coughlin, John P., 128 Wegman Pkwy.,Jer. City(9)
Dean, Guy K., Jr., Princeton rd., Plainsboro (11)
DePasquale, Filarginio, 560 Jersey av., Jer. City(9)
DiGioia, John, 287 Pacific av., Jersey City (9)
Doebele, William A., 1425 Wesley av., Ocean City(5)
Doody, William M., 19 Bentley av., Jersey City (9)
Elsasser, Theodore H., 7206 Park av., No. Bergen(9)
Evans, H. Walter, Jr., Fitkin Mem.Hosp.,Nept'e(13)
Feld, Leo, 155 Lexington av., Passaic (16)
Figurelli, Francis A., 88 Highland av.,Jersey City(9)
Finkelstein, Malvin, 2139 Boulevard, Jersey City(9)
Finn, Frederick A., 921 Bergen av., Jersey City (9)
Fort, William B., 147 E. Seventh st., Plainfield (20)
Frieman, Hyman, 744 Avenue C., Bayonne (9)
Gardiner, Muriel M., Brookdale Farm, Penn'gt'n(11)
Garfinkel, Abraham, 1801 Greenw'd av.,Trenton(11)
Garzieri, Anthony, 492 Union av., Paterson (16)
Gilmour, Thomas J., Jr., 19 Maple av., Keansb'g (13)
Gleeson, William J., 640 Bergen av., Jersey City (9)
Gnassi, Angelo M., 130 Wegman Pkwy., Jer. City (9)
Good, Richard B., 4619 Park av., Union City (9)
Granger, James R., 235 Spring st., Trenton (11)
Halpern, Sophia L., 1311 Palisade av., Union City(9)
Hayden, Walter G., 504 Main st., Toms River (15)
Hogan, James J., 211 High st., Mount Holly (3)
Hutchinson, Harry F., 209 Passaic av.,Spring L.(13)
Ivory, Harry S., Richmond av., Pt. Pleasant (15)
Jaffe, Gorman, 626 Sixth st., Lakewood (15)
Jaffe, Herman M., 2600 Boulevard, Jersey City (9)
James, J. Thomas, 45 Vandeventer av.,Princet'n(11)
Jones, Clement M., 454 Boulevard, Bayonne (9)
Katz, Jacob D., 38 Bentley av., Jersey City (9)
Knapp, Victor, 505 Second av., Asbury Park (13)
Kresch, Philip, 86 West 34th st., Bayonne (9)
Krohn, Marc, Campbell av., Belford (13)
Lane, Milton, 900 Stuyvesant av., Union (20)
Largay, Arthur O., 937 Avenue C, Bayonne (9)
Leir, J. Krevin, 2787 Boulevard, Jersey City (9)
Lewis, Arthur J., 1123 Park av., Hoboken (9)
Linden, Mortimer H., 45 Clendenny av., Jer. City(9)
Lynch, Cornelius G., 1731 32nd av.,Seattle,Wash.(11)
Manser, Ernest E., 321 Haddon av., Collingswood(4)
Marshall, Irving, 25 Kensington av., Jersey City(9)
Mathesheimer, Jacob L., 280 Old Bergen rd.,Jer. C.(9)
McLoughlin, Frank J., 2595 Boulevard, Jer. City (9)
Meltsner, Louis, 904 Hudson st., Hoboken (9)
Mersheimer, Christian H., 15 Reservoir av.,Jer. C.(9)
Miller, Max H., 311 60th st., West New York (9)
Miller, Reginald C., 1420 Greenwood av.,Trenton(11)
Milligan, Robert B., 726 Watchung av., Plainfl'd(20)
Munro, Charles A., Main st., Marlton (3)
Neals, Huerta C., 130 Atlantic st., Jersey City (9)
Newman, Abraham J., 132 Manhat'n av.,Jer. City(9)
O'Hanlon, George, Medical Center, Jersey City (9)
Ondovchak, M. F., 10 E. King's Hwy.,Mt.Ephr'm(4)
Osher, Morris M., 100 Martine av., N., Fanwood(20)
Oshrin, Henry, 7500 Bergenline av., No. Bergen (9)
Pastras, Thomas, 116 W. Collings av.,Collingsw'd(4)
Phillips, Claude B., 885 Haddon av., Collingswood(4)
Radest, Louis J., 347 Broadway, Paterson (16)
Reingold, Alexander, 221 Garden st., Hoboken (9)
Riese, Jacob A., 6012 Palisade av., W. New York(9)
Robbins, Morris A., 39 W. Main st., Columbus (3)
Rozett, Oscar, 19 Prospect st., Summit (20)
Sandick, Herbert, 12 Lincoln Pwy., Bayonne (9)
Schenker, Sarah S., 1009 Garden st., Hoboken (9)
Schirmer, William, 428 Broad st., Elizabeth (20)
Schulman, Jesse, 111 Forest av., Lakewood (15)
Schwager, Alfred J., 629 W. State st., Trenton(11)
Schwarz, Henry J., 8534 Boulevard, North Bergen(9)
Schweizer, Roman G., 36 Summit rd., Elizabeth (20)
Scott, John J., 6 Zerman pl., Weehawken (9)
Seligmann, Fred S., 501 32nd st., Union City (9)
Sell, Frederick W., 167 W. Emerson av.,Rahway(20)
Shapiro, Marvin I., 1243 Stuyvesant av., Union (20)
Shapiro, Nathaniel J.,212 Palisade av.,Union City(9)
Siedenburg, R. H.,Box 222, Bayway Ref.,Linden(20)
Sigman, George, 254 Union st., Jersey City (9)
Silver, E. Drew, 136 Stockton st., Hightstown (11)
Sinnott, John, Jr., Rumson rd., Rumson (13)
Small, E. Lester, 30 Branch st., Medford (3)
Snyder, W. Jay, 74 Columbia ter., Weehawken (9)
Sperry, Robert, 1500 46th st., North Bergen (9)
Steitz, John A., 200 Garden st., Mount Holly (3)
Temes, J. Howard, 2250 Boulevard, Jersey City (9)
Terwedow, Henry, 7707 Boulevard, North Bergen(9)
Thomas, Ralph B., 793 Montgomery st., Jer. City(9)
Tomaluoli, Michele, 19 76th st., North Bergen (9)
Towbin, Adolph, 326 Third st., Lakewood (15)
Voss, John C., 634 Thomas av., Riverton (3)
Wantoch, Joseph, 14 Carteret av., Carteret (12)
Wells, William C. V., 220 Hazel av., Delanco (3)
Whalen, Edward C., 942 Cooper st., Camden (4)
White, Hugh M., 901 Summit av., Jersey City (9)
White, Richard E., Grandview av., Wyckoff (16)
White, Thomas J., 50 Glenwood av., Jersey City (9)
Woltmann, Charles E., 805 Garden st., Hoboken (9)

ASSOCIATE MEMBERS

Gearren, John B., 100 Farnsworth av.,Bordent'n(11)
Hawke, Edward K., N. J. State Hosp., Trenton (11)
Rogers, Fred B., Donnelly Mem. Hosp., Trenton(11)
Sawchak, Walter G., 1325 S. Broad st., Trenton(11)
Tyler, Harmon Y., St. Francis Hosp., Trenton (11)
Wallis, Josiah K., 230 Nassau st., Princeton (11)

HONOR TO DR. CHARLES SCHNEIDER

At a recent meeting, the Physicians' Club of Essex County signalled the 50th anniversary of Dr. Schneider's entry into practice by adopting the following resolution:

Whereas: Dr. Charles Schneider has been in the active practice of medicine for fifty years and,

Whereas: he has given freely of himself to indigent and private patients in the hospitals where he is on the attending and consulting staffs and,

Whereas: he is among the pioneers in radium and physiotherapy in this area, and

Whereas: he is known among us as an honorable practitioner and a member of the Physicians Club of Essex County, be it therefore

Resolved: That we offer him our sincere felicitations on this the anniversary of his half century of the practice of medicine.

TO THE LADIES

The following editorial item appeared in the February 1950 Bulletin of the Hudson County Medical Society and is reproduced here as a matter of interest to all physicians in the state.

At a recent meeting in Trenton, one of our State Medical Society executives revealed to your editor a brief resumé of the truly amazing work being done by The Woman's Auxiliary to The Medical Society of New Jersey. The ladies have compiled a remarkable record of service to and cooperation with the doctors who have called upon them. Space restrictions do not permit even an attempt to enumerate the successful projects previously and presently energized by the Auxiliary. Take my word for it, however, that were you appraised fully of their accomplishments, you would never refer to our partners as "the weaker sex". While this is written as a belated appreciation of work well done but rarely publicized it is not intended to end there. Upon investigation, it appears that the accomplishments of the Auxiliary are in direct proportion to the recognition and cooperation accorded them by their county medical societies. This fact is predicated upon nothing more subtle than their organization's constitution which prohibits them from initiating any medical project except upon the request of or following the approval of the Advisory Boards of the Medical Society. The important point is that some of the Society members have for reasons unknown, failed to offer the Auxiliary anything more than intolerance and a refusal to sanction their gracious willingness to help. Three counties have flatly refused to permit the formation of a Woman's Auxiliary. Let's be practical and admit that the defeat of socialized medicine is far from an accomplished fact and therefore we are in no position to refuse aid of the quality and quantity the Auxiliary can give. The ladies have contacts and influence in many places; they have entré to many organizations we need to reach and these women play a major part in moulding public opinion. In our current educational campaign it would be wise to realize that the family doctor is usually chosen by the mother of the family. Who can better reach her with our warning against statism than our own womenfolk? Our opponents have not been unmindful of the power of female support but rather have utilized it at every opportunity. This is no time to handicap ourselves with the mid-Victorian concept that women belong only in the home. This campaign is directed against a political and economic issue and the ladies have long since won their letters in both fields. Wake up, gentlemen. Urge your wives to join the Auxiliary. Urge your county society to seek the aid so easily available and recall the sagacity in the advertisement— "never underestimate the power of a woman".

Arthur P. Trewhella, M.D.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

NEW JERSEY'S FIRST NEED IN PUBLIC HEALTH

In his report submitted to Governor Driscoll on March 15, 1950, State Health Commissioner, Daniel Bergsma emphasized New Jersey's need of legislation for larger local health units. The section of his report dealing with this subject is as follows:

"With the reorganization of the State Department of Health into six bureaus and the projection of the plan for creation of four State district health offices, the initial problem which faced my administration as State Commissioner of Health, that of reorganizing the State Department of Health, is approaching a virtual conclusion in its immediate aspects. The long range problem of insuring that the people of New Jersey will be able to provide themselves with better local public health services remains with us. Modern effective local public health services for the people in their own communities, provided through cooperative effort on the part of their own local municipal and township governments is a vital present need throughout most of our State. It is not the responsibility of the State Department of Health to provide local health services and the Department has no desire to usurp even a portion of this local responsibility and authority.

"The Legislature clearly placed the authority and responsibility for local health services in the first local health act of 1880 upon the municipal governments so that the work of the State Department of Health in this area is not to render local health services, but to see that it is possible for municipal governments to meet their obligations in this field.

"This major public health problem of local health services for all of our people is one we share with other states. We have long prided ourselves in New Jersey on our system of strong local government and local responsibility for governmental services, but at the same time most of our municipalities and townships have too small a population to support the staff and provide the facilities necessary for the operation of full time local health services. Various means of accomplishing this have been considered during the last twenty-five years and several methods have been tried without marked success.

"The appointment of the Governor's Committee on Local Health Administration which held its first meeting on February 24, 1950, is the latest of the many efforts which have been made during the last 25 years to help us reach a satisfactory solution of this long standing problem.

"The regional local health district bill, Assembly Bill No. 2, introduced this year by Assemblyman Fraser of Atlantic County, contains the same provisions that Senate Bill No. 189 of the 1949 Legislature did as amended. The purpose of this bill is to provide a practical method by which municipalities with small populations may join together in providing needed local health services through regional local health districts in a manner similar to the formation of the familiar consolidated school districts.

"This bill is a product of the thought and experience of many people—of health officials and workers, of health and civic organization leaders, of local government officials and of interested citizens. It is a product of group thought and group study extending over a period of a quarter of a century.

"The bill provides for regional local health districts under a regional local board of health which will have the full authority of our present municipal local boards of health and which will provide local health services within the municipalities and townships making up the district.

"We want and we need better and more complete local public health services; we want and we need to safeguard our local government system. Whatever legislation is finally enacted, it must meet these two requirements. We have waited overlong in reaching our decision on this vital issue and in making provision for a practical method of providing local health services. Indeed we have delayed so long in studies and surveys and debates that if long continued we may reach a point where we will believe ourselves incapable of decision and the problem impossible of solution. Let us get on with the job."

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, February 10, DR. M. BROWNE HOLOMAN, presiding.

DR. LOUIS A. M. KRAUSE, associate professor of Medicine, University of Maryland, Baltimore, was the guest speaker. His subject was "The Physical Examination". This brilliant presentation was so comprehensive that it precluded discussion.

The annual Report of the Atlantic City Emergency Erosion Committee was brought to the attention of the Society. The Committee requested the consideration and support of the Society of this important work, and the president urged that the members give serious thought to this vital matter.

Dr. Major, reporting on the requested approval of the Hewson Clinitron, a laboratory appliance to be used in State Clinics for mass blood surveys in diabetes, stated that the committee had decided to give its endorsement in a limited form. It was voted that the Society endorse the use of the Hewson Clinitron in clinics controlled by the State, and financed by funds supplied by the State.

Dr. Shavelson expressed his thanks to the members for their cooperation and support of the current 1950 Heart Campaign. He urged our continued and further effort in this worthy cause, and announced that the headquarters of the Heart Association are located in the Professional Arts Building, Suite 414.

Dr. Diskan, reporting for the broadcasting committee, stated that broadcasts had already been initiated, and will be made regularly every Friday at 7 p. m. He stressed the importance of this public relations service, and the president requested every member to contribute as much time and interest as possible.

BERGEN COUNTY

E. V. Sexton, M.D., Secretary

The medico-legal aspects of drunken driving was the theme of the February 14 meeting of the *Bergen County Medical Society*. Held jointly with a session of the Bergen County Police Chiefs' Association, the meeting was called to order by the medical society's president, DR. JOHN L. OLPP. The first speaker, DR. RUSSEL K. TETHER spoke of the medical aspects of the problem of the drinking driver. He was followed by MR. WALTER G. WINNE, prosecutor of Bergen County who reviewed the law-enforcement aspects of the same problem. Next speaker was Mr. MICHAEL ORECCHIO, chief of the county detective force who outlined the immediate goals in the county's program to reduce drunken driving and improve its law enforcement technics.

As a demonstration, the police officers staged a simulated arrest and mock trial. DR. J. M. MACKELLAR demonstrated the examination of the allegedly drunken driver and the use of the one-page examination form worked out for this purpose by the medical society in cooperation with the police chiefs. The next item on the program was a demonstration of the "Drunkometer", a balloon into which the suspect blows, and from which the expired air can be analyzed for alcoholic content. The demonstration was in charge of LIEUTENANT VINCENT FOX. On motion of Hackensack's police chief, WILLIAM MUNZ, the two societies then adopted a resolution which urged: (a) wider use of the driver medical examination form, (b) further study of the "drunkometer", and (c) provision of legal protection for doctors who testified in drunken driving cases in local police courts.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on March 9. The meeting was called to order promptly by the president, DR. E. V. DAVIS at 9 p. m.

The speaker was DR. PAUL COLONNA, head of the Orthopedic Department of the Hospital of the University of Pennsylvania. He was asked to speak on the subject of "Backache", and in the time at his disposal, he very ably touched on some of the more important phases.

We also had the pleasure of hearing the executive officer of The Medical Society of New Jersey. He discussed the progress that has been made in the National Education Campaign of the A.M.A. to date. He also mentioned some future plans, and he passed on a few helpful suggestions to the members present.

DR. JACOB M. DAVIS of Burlington was chosen to represent the county as the most outstanding General Practitioner. Dr. Davis started practice in Burlington over fifty years ago when travel was slower and medicine less complicated. He progressed with the times, and he is still doing a "bang-up" job in the same Burlington today.

Dr. Bray announced the Essay Contest sponsored by Association of American Physicians and Surgeons for Junior and Senior High School students on the topic "Why Private Practice Furnishes this Country with the Finest Medical Care". Everyone was in favor of the contest, but, because of lack of time to organize it, the contest was voted down for this year.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

On February 14, the regular meeting of the *Cumberland County Medical Society* was called to order by DR. ANTHONY PINO, president, at Richards Farm on the Bridgeton Vineland Pike, at 2:30 p. m.

During the business session, changes which seemed advisable to the Committee for the Re-

vision of the Constitution and By-Laws were read. Dr. Carl Ware, president-elect and chairman of the Program Committee, announced plans for a social evening in March or April to include wives and guests of members. Dr. Ware proposed obtaining a celebrated speaker with *Compulsory Health Insurance* as his topic, suggesting two men who could best deal with the subject.

Dr. Ware opened the scientific session by introducing Charles P. Bailey, M.D., associate professor of Thoracic Surgery at Hahnemann Medical College and Hospital, who lectured on *Newer Trends in Thoracic Surgery*. Dr. Bailey's knowledge of a field of surgery which has made such tremendous strides in the past five years plus the fact that he had pioneered in many of these advances, made his brilliant presentation most impressive. Dr. Bailey stressed the fact that eminent surgeons who only six years ago had condemned certain operative procedures as radical and injudicious were now employing them routinely. After presenting modern concepts of surgery of the lung, he demonstrated highlights of the most recent surgical methods of dealing with congenital and rheumatic heart conditions. His aptitude as a speaker and his knowledge of the subject made Dr. Bailey's lecture extremely valuable to everyone in the society.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

In the absence of the president and vice-president, Dr. Chester I. Ulmer presided at the regular meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, February 16. With seven of our members vacationing in the sunny south, the attendance was not up to standard.

Dr. Philip Esero, who is practicing in Clayton, was elected to full membership.

After committee reports, Lewis Corell, M.D., director of the Municipal Hospital, Camden, N. J., gave a very interesting illustrated paper on "Virus Diseases of the Skin". Dr. Corell, who is on the staff of the Philadelphia Children's Hospital, showed beautiful photomicrographs and presented facts about herpes simplex, zoster, etc. Much discussion, mostly of the question-answer variety, followed.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its fifth regular monthly meeting of the season at Murdoch Hall, Jersey City Medical Center, February 7. Dr. Vincent P. Butler presided.

Dr. Ginsberg, chairman, reported that all four of this year's postgraduate courses have been fully subscribed, and will start on the scheduled dates, final reminders to the membership at large and specific directions to all registrants having been mailed within the past few days. Dr. Ginsberg thanked the Society for its enthusiastic cooperation in the postgraduate program this year.

In the report of Dr. Ruoff, chairman, Committee on Constitution and By-Laws, it was stated that the work of incorporating into the Constitution and By-Laws the changes and additions that have been adopted since its previous printing in 1935 has been completed. Since there will be no changes other than those already formally adopted, the Committee on Constitution and By-Laws recommended that the Society give its unanimous approval to printing the new edition without first publicizing it, thereby avoiding the considerable expense of a second printing. This recommendation was unanimously approved.

Dr. Meyerson, chairman, Annual Dinner Committee of 1950, confirmed the date and place of the Annual Dinner as follows: Saturday evening, April 15, 1950, at The Biltmore, Madison Avenue and 43rd Street, New York City. His committee, Dr. Meyerson said, is now working energetically on program arrangements.

Dr. Martin Turkish of Bayonne was elected to membership.

The guest speaker was Dr. Samuel F. Marshall, surgeon, Lahey Clinic, Boston. Dr. Marshall's subject was *Diagnosis and Treatment of Tumors of the Neck* (illustrated). Special attention was given to the differential diagnoses of the various swellings that occur in the neck.

Discussants were Drs. Bortone, Garibaldi, Halligan, Harris and Perlberg.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

The regular monthly meeting of the *Union County Medical Society* was held on March 10, at the Elks Club in Rahway. Dr. Frederic W. Lathrop, the president, called the meeting to order at 9 p. m., and introduced Mr. James E. Bryan, executive officer of The Medical Society of New Jersey.

Mr. Bryan discussed the educational program of the American Medical Association. In his interesting talk he also touched on the 1-10-20 plan which gives every physician an opportunity to join in the fight against socialized medicine; the Medical-Surgical Plan, medical leadership, self-discipline and exploitation; county press conferences, et cetera.

The essayist of the evening was Dr. George A. Schumacher, visiting physician in charge of Neurological Service, Bellevue Hospital; associate professor of Clinical Medicine (Neurology), Cornell Medical College, New York. He presented a very interesting paper on *Multiple Sclerosis* which elicited a very stimulating discussion among the members.

Upon recommendation of the membership committee, the following were admitted to full membership: Dr. R. Bruce Milligan of Plainfield; Dr. Marvin I. Shapiro of Union; Drs. Richard Henry Siedenberg and Stanley Lipson of Linden.

A vote of thanks was offered the Elks Club for entertaining the society. The meeting then adjourned and the members enjoyed the refreshments and social hour which followed.

WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETING

Mrs. Thomas H. McGlade, Press and Publicity

The Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey held its regular meeting at the Medical Society Executive Offices, Trenton, on March 13, 1950. Mrs. Norman Nathanson, president, presided.

The call to order, at 10:45 a. m., was followed by the regular agenda which included the minutes of the last meeting, the treasurer's statement, correspondence and reports by the state chairmen and county presidents.

Mrs. Pascal Baiocchi, Credentials chairman, reported forty-one members attending the meeting.

In her report, Mrs. Nathanson stressed the importance of receiving promptly, the annual reports from the state chairmen and the county presidents. These reports are to be mimeographed and compiled into booklet formation for the Convention.

Mrs. Harry Subin, Convention chairman, called attention to the convention dates. The Convention will be held on Monday, May 22, Tuesday, May 23 and Wednesday, May 24, 1950, at Haddon Hall, Atlantic City.

Mrs. Hortense Fuld Kessler, Commissioner of Public Utilities of New Jersey, was the guest speaker. Her topic was "Your Job in New Jersey". Mrs. Kessler listed the amount of money distributed to the various state institutions and the number of persons cared for by these institutions. She suggested certain means of social reform.

At the conclusion of Mrs. Kessler's talk, the meeting was recessed for luncheon. It reconvened for the afternoon session with the continuance of the county reports.

Under Revisions, a suggested change from one to two dollars dues per year for Membership-at-Large was discussed.

Those present were urged by Mrs. Paul E. Rauschenbach, to remember June 5 will be the date of the Public Relations Conference.

PUBLIC RELATIONS CONFERENCE

Mrs. Paul E. Rauschenbach, Chairman

The Woman's Auxiliary to The Medical Society of New Jersey and the New Jersey State Council for the Improvement of School Health Services will hold a joint Spring Conference on Monday, June 5, at The Medical Society of New Jersey Offices in Trenton. The general session will start the program at 10:00 a. m. with greetings from various state officers of both groups. This session will be followed by four panel discussions:

1—What constitutes an adequate school health examination?

2—Who is concerned with the school health program, and what minimum facilities should be provided for the health examination?

3—How shall we meet mental health needs in the school?

4—How shall the school meet the needs of the physically handicapped child?

After luncheon we will hear five minute reports of the four morning panels. This will be followed by a short address by some well known person.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publiicty

The Reverend James F. Boughton, pastor of the Wesley Methodist Church in Pleasantville, was enthusiastically received by the members of the *Woman's Auxiliary to the Medical Society of Atlantic County* at their regular meeting which was held on Friday evening, March 10, at the Hotel Traymore.

Mrs. Harry Subin, chairman of the Nominating Committee, announced the slate of officers for the year 1950-51: President—Mrs. Clarence Whims; President-Elect—Mrs. Matthew Molitch; First Vice-President, Mrs. F. Rolfe Westney; Second Vice-President—Mrs. E. Harrison Nickman; Treasurer—Mrs. Arthur Dintenfass; Recording Secretary — Miss Gertrude Guion.

Mrs. Louis Rosenberg, president, appointed delegates and alternates for the Annual Meeting.

Essex County

Mrs. Stuart Zeh Hawkes,
Chairman, Press and Publicity

The highlight of the February regular monthly meeting was the interesting lecture by the very charming Mrs. Emily Henry Bush. The Board meeting, followed by an informal lunch, preceded the regular meeting at the Academy of Medicine.

Your reporter was very happy to have the opportunity to preside at both meetings, carrying out the idea presented by our president, Mrs. Philip J. Santora, that the first vice-president should preside at one meeting a year. At the meeting Mrs. Robert Anderson, Jr., past-president, read the Nominating Committee's slate for the elections, which will be held in April. Mrs. Andrew Klein reported on the Nurse Scholarship Project stating that all the applicants have been interviewed. Both committees were commended for their fine work. Mrs. Joseph Clarken told of the Ways and Means Committee's plans for a theatre party at the Paper Mill Play House on April 12 for the benefit of the Nurse Scholarship Fund.

Mrs. Bush brought us her lecture "Shooting Stars", which she illustrated with colored slides. The slides were so realistic that we felt we were right in Hollywood with her.

Hudson County

Mrs. Arthur P. Trewhella,
Chairman, Press and Publicity

The annual Open Health Meeting of the *Auxiliary to the Hudson County Medical Society* was held on Monday afternoon, March 6, at Murdoch Hall, Jersey City. Mrs. Fred Sachs, chairman of Public Relations, presented Dr. Vincent Butler, president of the Hudson County Medical Society, as moderator of the forum on heart disease, its prevention and treatment. The following Hudson county physicians spoke on various aspects of the subject: Dr. Carroll Leevy on the various types of heart disease; Dr. Emil Grieco on prevention of heart diseases; Dr. L. J. Garibaldi on treatment of heart diseases; Dr. Thomas White on what can be done about heart diseases. Over 200 lay organizations were represented. A discussion period followed the talks. A variety of questions from the audience testified to the wide interest in the subject. A social hour with refreshments concluded the program. Guests of honor introduced by Mrs. Sidney Chayes, president, were: Mrs. Norman Nathanson, state Auxiliary president and Mrs. Paul Rauschenbach, state chairman of Public Relations; Dr. Arthur Trewhella and Dr. Raymond Driscoll of the Advisory Board.

Union County

One hundred fifteen members of the *Woman's Auxiliary to the Union County Medical Society* met on March 14, at the Park Hotel, in Plainfield, for a luncheon and fashion show.

Mrs. Austin Tidaback, of Union, was in charge of the program which featured a reception for the past presidents. Each past president was presented with a corsage. The business meeting was conducted by Mrs. Bertram Sauerbrun, of Elizabeth, president and included the election of officers. Mrs. William O. Wuester, of Hillside, was in charge of the balloting. The slate presented was Mrs. Graham Newberry, of Summit, President-Elect; Mrs. J. E. L. Imbleau, of Union, First Vice-President; Mrs. Walter Booth, of Elizabeth, Recording-Secretary and Mrs. Walter Phelan, of Elizabeth, Director.

Mrs. Asher Yaguda, state treasurer, addressed the members on "The Auxiliary, The Public and Their Chronically Ill". Mrs. Norman Nathanson, state president, commended the members for their activities during the year. A Membership Tea in Summit, on September 27, 1949, was the first of these activities. This was followed by an open Town Hall Meeting which attracted over four hundred laymen and doctors. Dr. James Norton, state president, and Arthur Conrad, formerly of the National Physicians Committee, discussed "Shall We have a National Health Act"? with Dr. Milton Tarlan of the Physician's Forum in New York and Harry Kranz, legislative chairman of the C I O of New Jersey. Robert Crane, editor and publisher of the Elizabeth Daily Journal, moderated this hotly contested debate which was broadcast over the local radio station. The Auxiliary Annual Ball took place on November 26, in Elizabeth, and was a very gay and festive event. On January 7, 1950, forty-seven potential nurses were entertained by the Auxiliary. These were high school girls interested in learning more about a nursing career. A panel of doctors' wives who were formerly nurses was led by Mrs. Graham Newberry. Their subject was "I was a nurse". Nurses from the three Training Schools in the county gave information concerning admission standards and present conditions in their respective schools. Dr. Herschel Murphy, of Roselle, brought greetings from the Medical Society to the girls. A Benefit Dessert Bridge was held in Rahway on February 7. It was attended by over two hundred persons.

These programs were directed by Mrs. Austin Tidaback, Program chairman. The last event of the season will be the Annual Meeting on April 18, at the home of the president, Mrs. Bertram Sauerbrun. The new officers will be installed at this time. There will be a speaker on Flower Arrangement.

Warren County

Mrs. Herman Smith, Press and Publicity

The *Auxiliary to the Warren County Medical Society*, at a luncheon meeting on February 21 heard a report by Mrs. William Varney, Public Relations chairman, on the Fifth Annual Home Safety Forum in Newark.

Mrs. Varney, the Auxiliary delegate to the forum, stressed the importance of taking everyday safety precautions in the home and emphasized woman's role in preventing household accidents.

Mrs. Ralph Buchanan, president, conducted the business session and introduced a new member, Mrs. John Hampton of Washington. The next meeting will be held March 21 at Morrie's Acres.

BOOK REVIEWS

Diagnostic Tests for Infants and Children. H. Behrendt, M.D. Pp. 529. Interscience Publishers, New York, 1950. ($7.50)

Scattered throughout the literature of pediatrics is a hodge-podge of clinical and laboratory tests which, properly administered, are helpful in the diagnosis of diseases of children. What Behrendt has done in this unique volume is to assemble these scattered tests, group them into clinical categories, tell the reader exactly how to perform and how to read each test. The book covers tests of digestive function, metabolism, liver activity, cardiovascular function, endocrine status, renal function, immunologic response and intelligence. On the whole, the volume is not one that will be referred to every day by even the busiest pediatrician or general practitioner. But this may be said: when the practitioner hurriedly wants to know about the technic or meaning of a test, he will find this a handy, much-appreciated, ready reference.

Ralph Neil Shapiro, M.D.

Operative Technic in Specialty Surgery. Edited by Warren H. Cole, M.D. Pp. 725. New York, Appleton-Century-Crofts, Inc., 1949. ($14.00)

This complete modern and up-to-date volume is presented in a most interesting and stimulating manner. In the chapter on plastic surgery, sound principles in wound healing and tissue repair are emphasized and considerable space is given to immediate débridement and plastic repair of the soft tissue wounds.

Surgery of the heart, the most recently and dramatically explored area of surgical attack, is presented in an interesting manner by the surgeon with the greatest experience in this field. The problem of cardiac arrest in the operating room is adequately covered.

Operative repair of simple fractures, modern treatment of compound fractures, and surgical approaches to the joints, are reviewed most effectively and here much is to be learned and appreciated by the interested surgeon. The up-to-date version of diagnosis and treatment of hematogenous osteomyelitis is reviewed by the outstanding authority on this subject.

The chapters on neurosurgery, including the central nervous system, peripheral nerves, and autonomic nervous systems, are brilliantly presented, effectively covering the entire subject.

The problem of radical surgery in the treatment of cancer is realistically offered in this text.

The chapters on gynecologic and genito-urinary surgery are covered adequately and competently.

As stated by Allen O. Whipple, the most interesting features of this volume are the choice of contributors, the emphasis on the part of each to give in detail the procedure and technic for each lesion which, in his own experience, has given the best results and, finally, the evidence in many of the chapters of the importance of training and experience in general surgery before undertaking the surgery of the specialties.

John J. Flanagan, M.D.

Normal Values in Clinical Medicine. By F. W. Sunderman, M.D., and Frederick Boerner, V.M.D. Pp. 845. Philadelphia, W. B. Saunders Co., 1949. ($14.00)

Normal values in virtually every field of clinical medicine have been assembled into this one volume. Starting with normal standards for the cardiovascular system, the book encompasses the fields of hematology, chemistry of the blood and body fluids, respiration, digestion, neurology, urology, gynecology, obstetrics, orthopedics, dermatology, ophthalmology, otology, rhinology, endocrinology and metabolism. Anatomic "normals" and dental standards are included as well as a section on miscellaneous data including statistical methods, food values, drug doses, isotope tables, and actuarial tables. Radiologic standards for heart size, bone age, etc. are also recorded.

In establishing standards of normal values in each section, the authors have drawn abundantly from the literature as well as from their own work. For example, five commonly used methods of determining the erythrocyte sedimentation rate are presented. Consideration is given to standard values for infants and children. Errors of methods and calculation are pointed out. The physical and chemical constituents of the blood are considered in great detail, and, in fact, each section is notable for the wide scope of anatomic and physiologic data that are presented. A resume table of values at the end of many of the chapters enhances the value of the book.

Because of the rapid progress of medical research, a volume of this type will require frequent new editions. In this first edition, the section on respiratory function fails to include the pulmonary function values worked out by Cournand and his colleagues, and the results of cardiac catheterization studies are not included. The section on electrocardiology briefly discusses esophageal leads, but normal tracings from these leads are not illustrated.

However, an occasional omission does not outbalance the total value of this book, which is to be commended for completeness and accuracy. It is recommended for all hospital, laboratory and medical libraries, and for those physicians who desire a complete compilation of normal clinical values.

Rowland D. Goodman, 2nd, M.D.

The Principles and Practices of Rehabilitation. Edited by Henry H. Kessler, M.D. Pp. 448 with 132 illustrations. Lea and Febiger, Philadelphia. 1950. ($9.00)

Dr. Kessler is one of the ornaments of our profession in this state as well as an active member of The Medical Society of New Jersey. He is a pioneer in rehabilitation, not only in its technical aspects, but also in its broader concepts, and in orienting the professional and lay public to its possibilities. In the last five years "rehabilitation" has become a fashionable word; almost, indeed a glamorous one. Everybody now is in favor of rehabilitation. But Henry Kessler was preaching the gospel

of rehabilitation back in the days when the word "cripple" conveyed contempt as well as defeat. Today it is no longer necessary to write a book pleading with the employer to "hire the handicapped", urging the public to accept the man with a defect or promising hope to the patient. In a word, we need no more books trying to sell the public on the idea of rehabilitation. What we do need is a book which lays down the *technic* of rehabilitation—and does it in a down to earth, usable fashion.

This is the book. It has practical chapters on the rehabilitative aspects of plastic surgery, occupational therapy, physical medicine, guidance, placement, tuberculosis, the amputee, the cardiac, blindness, deafness, neuropsychiatric disorders, cerebral palsies and the amputee. There is an interesting chapter on the organization and operation of a rehabilitation center which will serve as a blue-print for any community that can provide the leadership to set up such a center. It is a usefully—and profusely—illustrated volume. Twenty other persons (including Marvin Becker, a member of The Medical Society of New Jersey) cooperated with Dr. Kessler in writing the book. Six of the chapters are written by laymen, and they are well-done, competent, and inspiring chapters. The technical and surgical "know-how" is stressed, but the text has a breadth that carries it beyond the problem of craftsmanship into the wider fields of the legal, sociologic, historical and administrative aspects of rehabilitation.

There is no book quite like this in the entire field of medical literature. Many similar volumes will certainly be written in the future. By that time, this will have become a classic.

Henry A. Davidson, M.D.

Handbook of Digestive Diseases. By John L. Kantor,* M.D., and Anthony M. Kasich, M.D. 2nd ed. Pp. 658. St. Louis, C. V. Mosby Company, 1949. ($11.00)

The essential facts relating to gastrointestinal diseases are presented in concise yet thorough fashion in the *Handbook*. The organization of the text and the presentation of the subject are exemplary. The illustrations are notable, particularly the x-ray reproductions and the fine line drawings accompanying them. There is a judicious selection of references to the recent literature. The index is more than satisfactory and, in general, the book is handsomely produced.

A remarkable amount of valuable information has been crammed into this volume. The chapter on history and physical examination is extremely well done. Chapters on diagnostic methods, special tests, anomalies, diseases of the mouth, esophagus, small intestines and colon are concise and to the point. The section on diseases of the liver is noteworthy and recent advances in this field are clearly and critically evaluated. The discussion of cancer of the pancreas contains many useful suggestions. The importance of parasitic diseases, especially amebiasis, is stressed and the sources of digestive symptoms arising outside of the gastrointestinal tract are considered. There is a significant chapter on psychiatric aspects of digestive diseases consistent with the broadened, indispensable psychosomatic approach expected today from the internist. A short, informative chapter on gastrointestinal allergy, written by Harry Swartz, is included. This complete and up-to-date *Handbook* should be in the hands of every physician called upon to treat patients with gastrointestinal diseases.

Herbert Greenfield, M.D.

* Deceased.

Clinical Radiation Therapy. By Ira I. Kaplan M.D. With 614 illustrations. 2d ed. Pp. 844. New York, Paul B. Hoeber, Inc. ($15.00)

This excellent standard reference has now been enlarged and brought completely up to date. The benign and malignant conditions amenable to radiation therapy are discussed in full detail according to bodily systems.

The author is a pioneer in the radiation therapy of sterility. Stimulating doses of x-ray therapy in his hands have already caused the conception of 140 normal children to date, in cases where all other measures failed. He is now carefully checking the second generation for genetic abnormalities which (critics of this type of therapy insist) may be produced. So far no aberrations have been found. Certain types of endocrine amenorrhea have also been successfully treated, with establishment of normal menstrual periods. There is also some new work being done on the treatment of dysmenorrhea in which the spleen is radiated. The mechanism of this action is unknown but some successful cases are reported.

The internist may be interested in reviewing the treatment of such conditions as the lymphoblastomas and blood dyscrasias. It is the author's contention that x-ray therapy is still the treatment of choice for polycythemia vera, in spite of the advent of radioactive phosphorus, in that it produces a more permanent remission. He also feels radiation to be the superior therapy for lymphoblastomas as well, other medications being either too toxic or, as in the case of polycythemia, less permanent. There is also a discussion of Hutton's work, in which cases of essential hypertension are supposed to have been successfully treated by radiation of the adrenals and the pituitary. Another aspect of internal medicine is the therapy of certain chest conditions, such as virus pneumonia, unresolved pneumonia, and persistent, undiagnosed cough in children.

Treatment of malignancies represents the bulk of the text, and the diagnosis and therapy of each type malignancy is clearly covered, including both the clinical and the radiologic aspects.

Sylvia Beckel, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **April, 1950** **No. 4**

WITH the tuberculosis death rate dropping so rapidly, the question is sometimes asked why larger amounts are needed each year for the control of this disease. The answer, in a nutshell, is that eradication of tuberculosis in this country within a relatively few years is now the goal. In the past the best that one could attempt was to keep the disease under control. It now appears that with the concentrated effort of all interested groups, tuberculosis may be conquered in most communities in the foreseeable future.

TB—THE COSTLY DISEASE

If tuberculosis is to be eradicated, adequate facilities must be made available for chest X-rays of all apparently healthy adults, for suitable follow-up of all cases needing further study, and for medical care.

Sufficient hospital beds must be made available to insure care and isolation for all persons with active disease; adequate financial provision must be made for the families of hospitalized patients; funds must be at hand to insure the rehabilitation of ex-patients. Above all, health education must be carried to a far greater proportion of the population. Medical research must continue on many fronts. Pensions must be provided for tuberculous veterans. All these facilities and activities require vast sums of money both from official and voluntary sources.

Best estimates indicate that in 1948 the tuberculosis control program in the United States cost approximately 350 million dollars. This amount makes no allowance for hospital construction, for depreciation of hospital buildings, or for the training of professional personnel.

The Public Health Service appropriation for tuberculosis control is now about ten million dollars annually; the Christmas Seal Sale is more than 20 million dollars; state health department funds for tuberculosis work have increased materially in the past decade. The Veterans Administration is now spending much more on hospitalization and rehabilitation of the tuberculous. Pensions for veterans whose major disability is tuberculosis amounted to 86 million dollars in the calendar year 1947.

Not only are official and voluntary health agencies spending huge amounts on community-wide X-ray surveys, but industrial firms and labor unions are financing projects of this type. Moreover, in recent years it has become necessary to devote large sums to the recruitment and training of executive and professional health workers.

In addition to the estimated annual cost of approximately 350 million dollars, so-called "hidden costs" of tuberculosis run well into the hundreds of millions. Among these costs are the potential annual losses in wages, in production, and in net future earnings incurred by those persons who die or are incapacitated by tuberculosis. Since these estimates overlap to some extent, no total can be shown for potential losses of this type.

A study made in 1943 estimated that the potential loss of wages in that one year by those who were ill or who died of tuberculosis was nearly 200 million dollars. The potential loss of goods and services which might have been produced in that year was 350 million dollars. There is, in addition, a potential loss in the net future earnings of those who died in 1943 which came to more than 200 million dollars.

None of these estimates makes any allowance for the cost of the many thousands of new beds needed. This cost would come to approximately 200 million dollars for about 40,000 new beds; if the 80,000 beds, said by certain authorities to

be needed, were to be built, the estimated cost would be 400 million dollars. Such an enormous outlay may be considered justified, even in the face of a rapidly falling tuberculosis death rate, since at the end of a decade or two the hospitals would be available for chronic disease patients. Such facilities will become increasingly necessary since our population is aging rapidly. Moreover, in view of accelerated world travel, it will still be necessary some years hence to appropriate a moderate amount to maintain hospital and other facilities for tuberculosis control.

The tuberculosis death rate has now dropped to 30 per 100,000 population in the country as a whole, compared with a rate of 194 in 1900. The sensational decline in the over-all mortality rate from this disease during the past five decades has tended to obscure the fact that the death rate varies widely according to sex, age, color, economic status, and locality. Thus, the death rate of 30 must be accepted as an average only.

Mortality from tuberculosis is twice as high among men as among women. It increases directly with age and is especially high among older men. The death rate among Negroes is three times as high as among white people. In one state, the death rate is still 100, while one or two states now have rates of less than 10. Similarly, a few of our large cities have outstandingly high rates. Mortality is seven times as high among unskilled laborers as among professional persons. Thus it is evident that in numerous groups a great deal of concentrated effort must be exerted if the disease is to be brought under control at any time in the near future.

For all these reasons, the cost of tuberculosis control cannot be lessened in any community until its tuberculosis death rate reaches a level of less than 10 per 100,000. When that goal is attained, it is possible that much of the available funds may be diverted to other phases of health work. Until then, no let up can be planned.

Editorial, Mary Dempsey, Statistician, National Tuberculosis Association, Bulletin of the National Tuberculosis Association, December, 1949.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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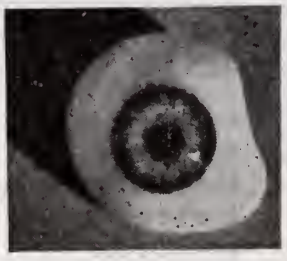

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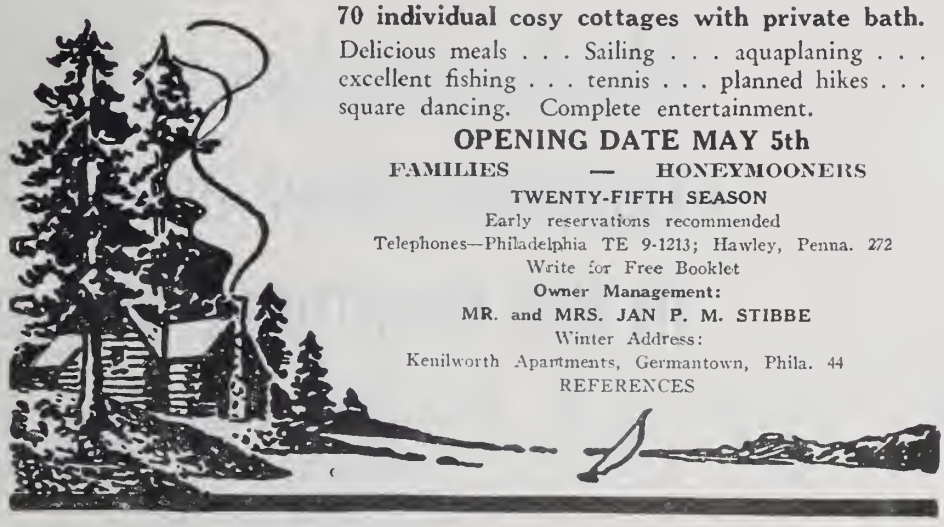

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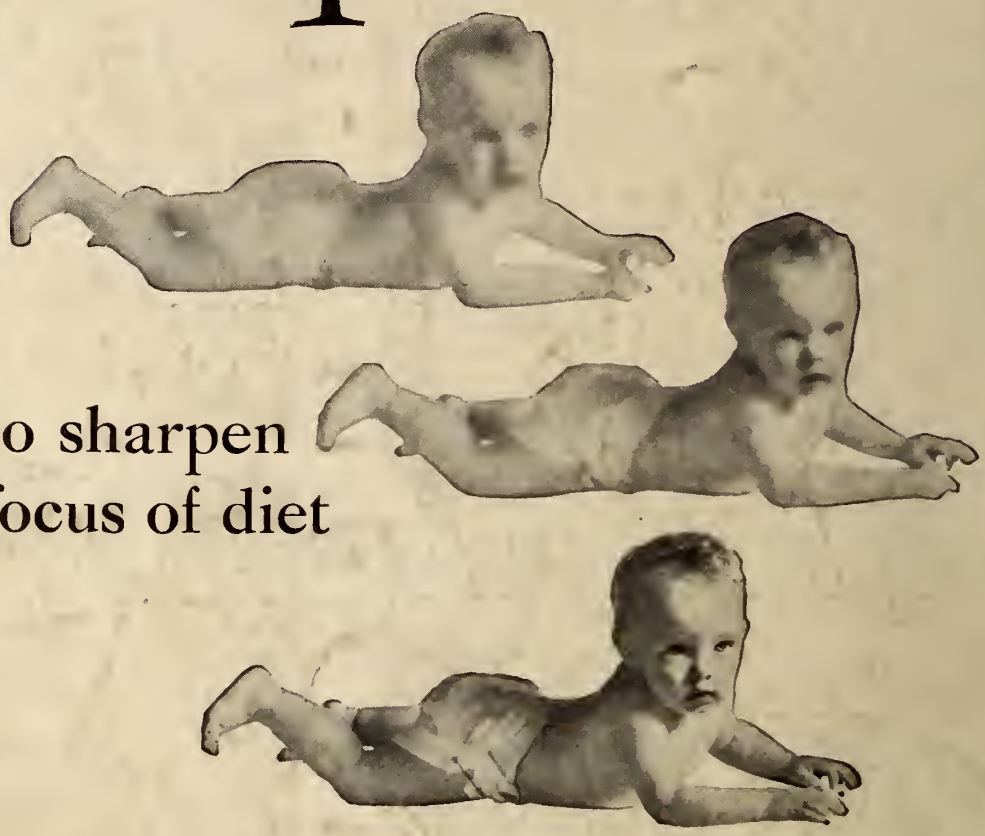

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CONTENTS—Pages 191 to 258

PAGE

EDITORIAL—
- Editorial in Nine Words 191
- Annual Meeting 1950 191

PROGRAM OF THE ANNUAL MEETING—
- Daily Schedule 192
- General Session 193
- Scientific Sections 193
- Agenda of the House of Delegates 196
- Reference Committees 196
- Dinner Dance 197
- Special Events 197
- Woman's Auxiliary 197
- Scientific Exhibits 198
- Technical Exhibits 201

ANNUAL REPORTS 206
(Index to Annual Reports on page 205)

SUPPLEMENTARY LIST OF MEMBERS No. 2 254

BOOK REVIEWS 255

TUBERCULOSIS ABSTRACTS 257

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**Pitt, C.K.: The Art and Science of Artificial Infant Feeding, J.M. Asso. Ala. 19:101 (Oct.) 1949.*

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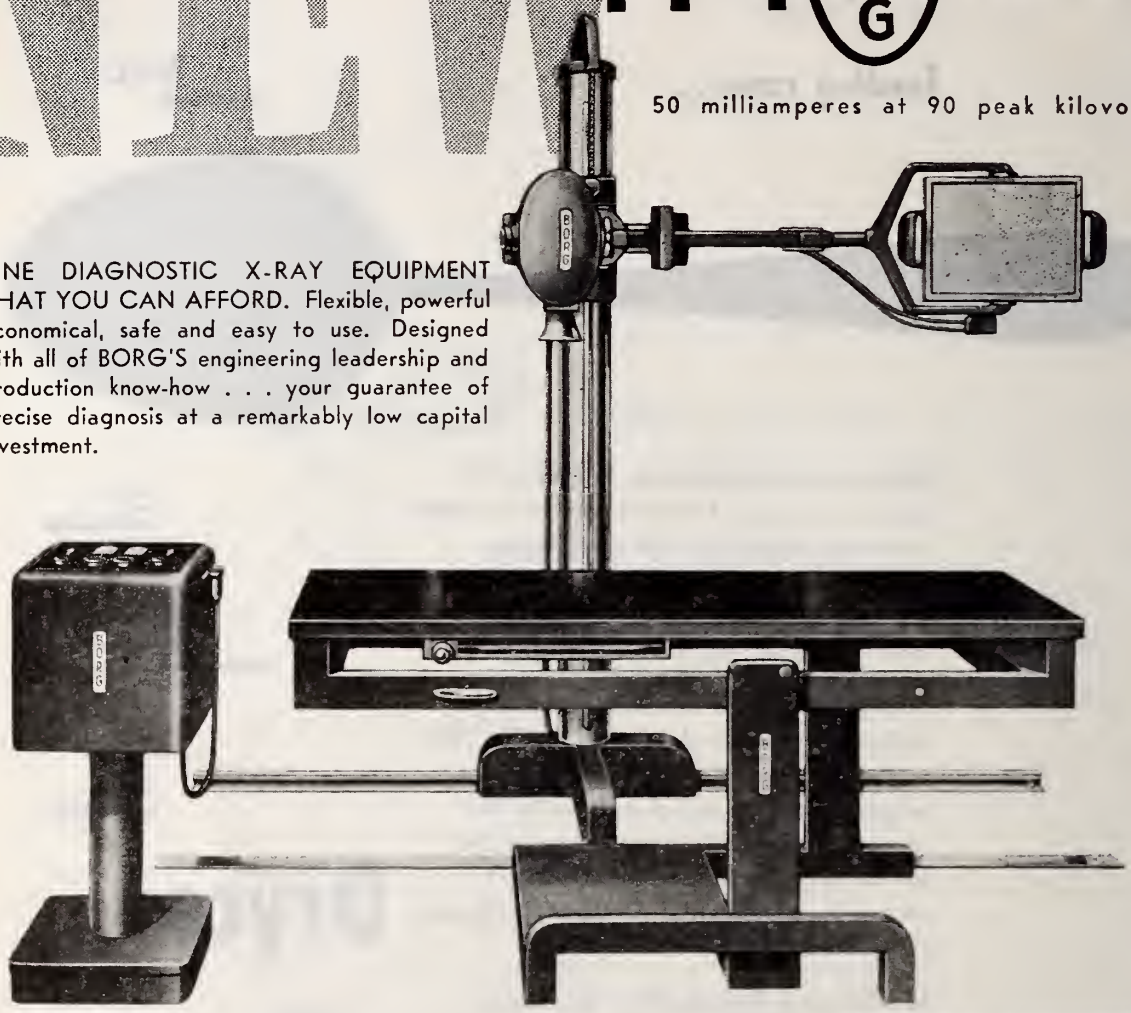

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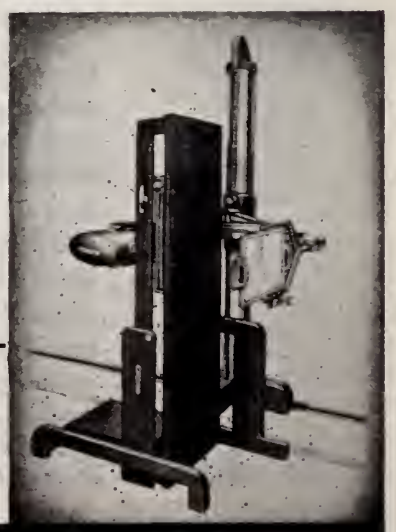

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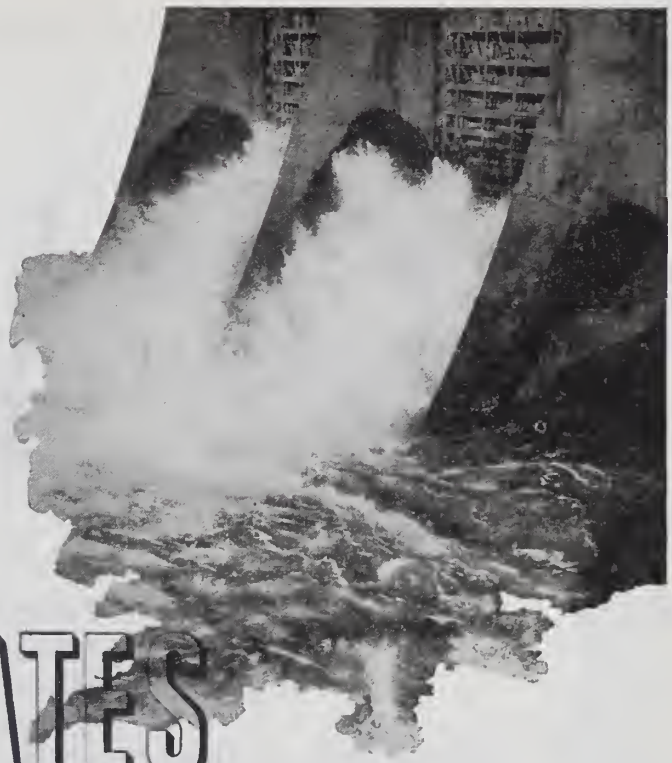

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1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744.

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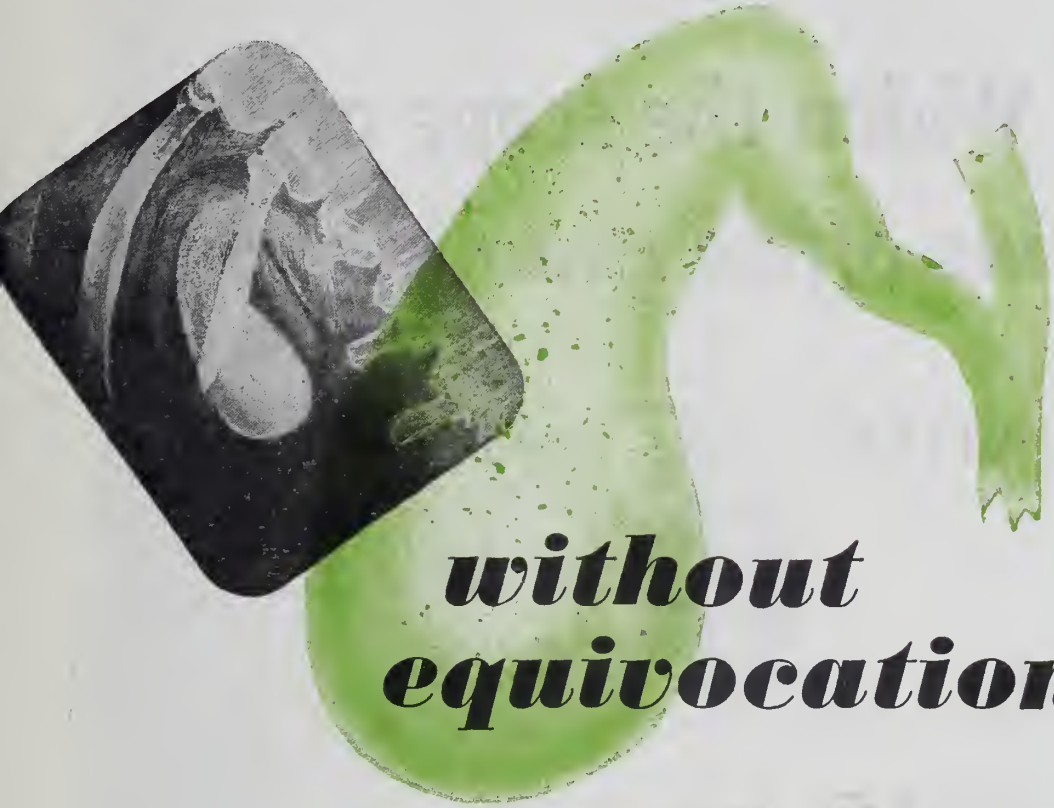

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1. Brewer, A. A.: Radiology 48:269, 1947.

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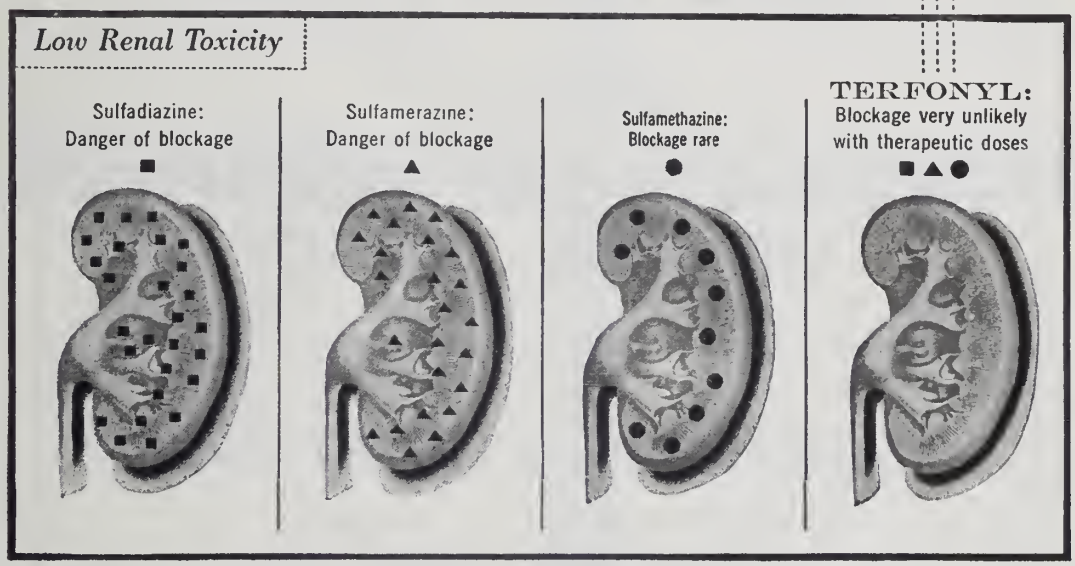

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Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

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Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

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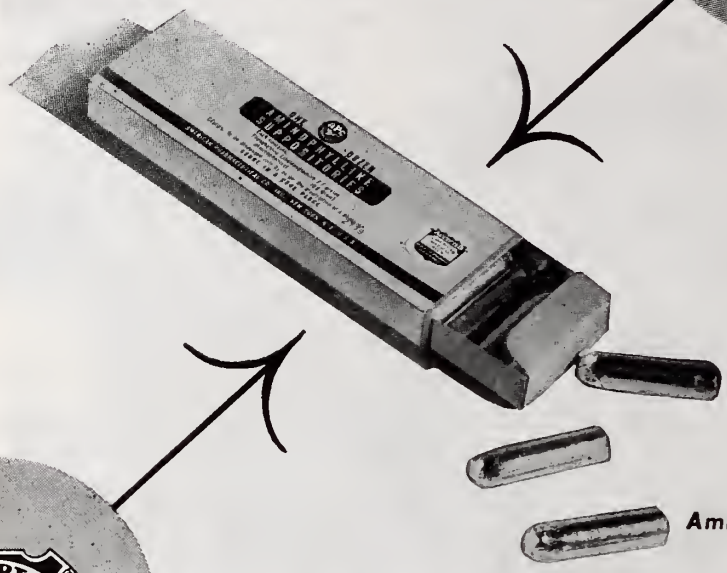

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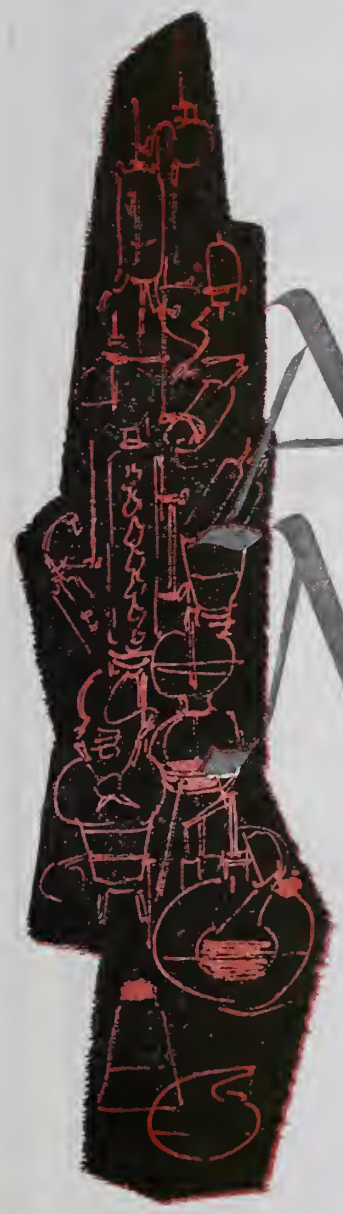

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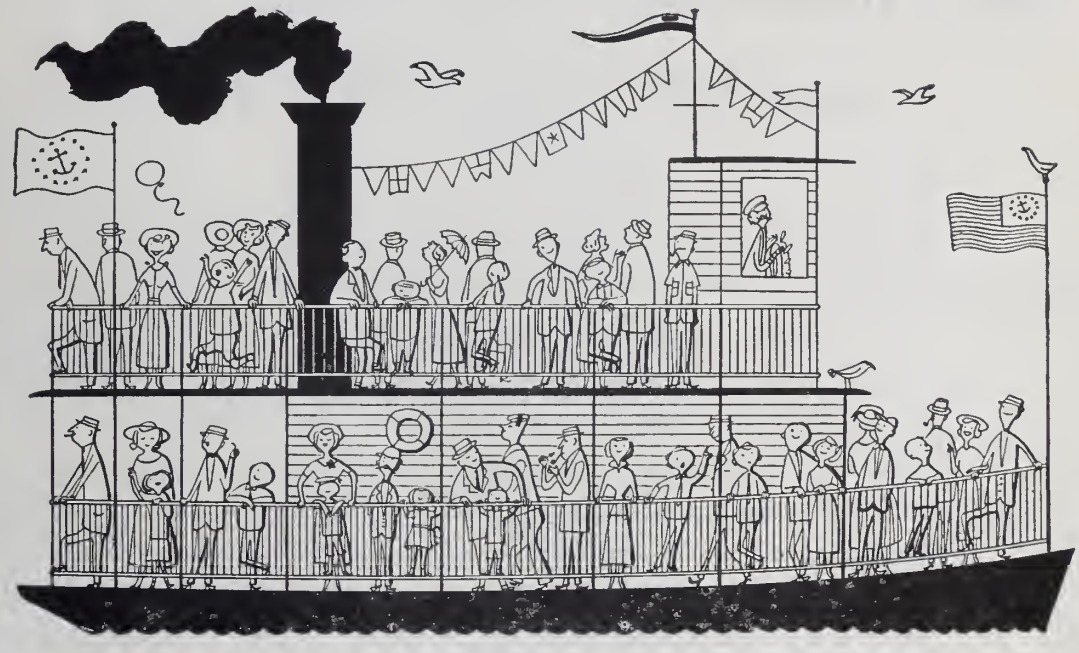

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Extensive studies* by the Bureau of Human Nutrition have established that breakfasts rich in protein and supplying 500 to 700 calories, effectively promote a sense of well-being, ward off fatigue, and sustain blood sugar levels at normal values for the entire morning postbreakfast period.

These physiologic advantages are related mainly to the protein content rather than to the caloric content of the breakfast. In fact, when isocaloric breakfasts were compared, those with the higher amounts of protein led to the greatest beneficial effects. Breakfasts providing the lower quantities of protein (7 Gm., 9 Gm., 16 Gm., and 17 Gm. respectively) produced a rapid rise in the blood sugar level and a return to normal during the next three hours. Breakfasts providing more protein (22 Gm. and 25 Gm. respectively) produced a maximal blood sugar rise which was lower than that following the breakfasts of lower protein content, but the return to normal was delayed beyond the three hour period.

The subjects on the higher protein breakfasts "reported a prolonged sense of well-being and satisfaction." The findings indicated that the beneficial effects of the high protein breakfast on the blood sugar level may extend into the afternoon.

Meat, man's preferred protein food, is a particularly desirable means of increasing the protein contribution of breakfast. The many breakfast meats available are not only temptingly delicious and add measurably to the gustatory appeal and variety of the morning meal, but they also provide biologically complete protein, B-complex vitamins, and essential minerals. *Meat for breakfast, a time-honored American custom, is sound nutritional practice.*

*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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EDITORIAL IN NINE WORDS

"The 1948 infant mortality rate for the United States was the lowest on record according to figures released today by Federal Security Administrator, Oscar R. Ewing." (From FSA release dated March 27, 1950.)

Is this the system Mr. Ewing wants to change?

ANNUAL MEETING 1950

Doctors in Oshkosh and Oregon look wistfully towards Atlantic City where many medical conventions are held. In spite of time, cost and distance, hundreds of them manage to get there. But most of the doctors west of the Susquehanna have to stay home when meetings are held in the world's playground. It takes too long to get that far east—too much time away from the office, too expensive for rail fare, too long to drive. So those physicians unfortunate enough to be living outside of New Jersey can dream about Atlantic City in the spring. But for most of them, that's about all. They would like to come to a medical convention on the boardwalk. Item, the chance to meet old friends; item, the kaleidoscope of exhibits; item, the chance to be in on the ground floor where major policy problems of organized medicine are being thrashed out; item, keeping in touch with progress in medicine; item, a compact postgraduate course in a few days; item, a good time; item, a relaxing vacation in the world's most invigorating resort. A saline tonic for what ails you.

To the doctor from Dallas or Denver, this is, most of the time, but a pipe dream. He can't make it for three good reasons. But for the doctor from New Jersey, what can be his reason for staying home on May 22, 23 or 24?

Run a diagonal line through those pages in the appointment book and see Atlantic City in Maytime.

THE 184th ANNUAL MEETING
OF
THE MEDICAL SOCIETY OF NEW JERSEY
HADDON HALL, ATLANTIC CITY
May 22, 23 and 24, 1950

DAILY SCHEDULE

SUNDAY, MAY 21, 1950

3:00 p. m.—Registration Opens
Lounge Floor
6:00 p. m.—Dinner—Board of Trustees
Bakewell Room, First Floor
8:00 p. m.—Board of Trustees
Rowsley Room, First Floor
Judicial Council
Room 134, First Floor

MONDAY, MAY 22, 1950

9:00 a. m.—Exhibits Open
Lounge Floor
10:00 a. m.—Scientific Sections:
Surgery
Vernon Room, Lounge Floor
Pediatrics
Rutland Room, First Floor
Eye, Ear, Nose and Throat
Viking Room, Thirteenth Floor
12:00 noon—Luncheons:
Section on Radiology
Room 1337, Thirteenth Floor
Section on Surgery
Rowsley Room, First Floor
Section on Pediatrics
Bakewell Room, First Floor
Section on Eye, Ear, Nose and Throat
Room 1333, Thirteenth Floor
1:00 p. m.—Tour of Exhibits
Lounge Floor
Auxiliary Panel Discussion
Mandarin Room, Thirteenth Floor
2:00 p. m.—Scientific Sections:
Medicine
Vernon Room, Lounge Floor
Obstetrics and Gynecology
Rutland Room, First Floor
Radiology
Viking Room, Thirteenth Floor
3:30 p. m.—Auxiliary Informal Tea
Tower Room, Thirteenth Floor
4:00 p. m.—Tour of Exhibits
Lounge Floor
6:30 p. m.—Auxiliary Fellowettes' Dinner
Mandarin Room, Thirteenth Floor
Fellows' Dinner
Rowsley Room, First Floor
8:30 p. m.—Nominating Committee
Bakewell Room, First Floor
Round Table Discussion on Post-Graduate Medical Education
Tower Room, Thirteenth Floor

TUESDAY, MAY 23, 1950

9:00 a. m.—Tour of Exhibits
Lounge Floor
9:30 a. m.—Auxiliary General Session
Mandarin Room, Thirteenth Floor
10:00 a. m.—House of Delegates
Viking Room, Thirteenth Floor
12:00 noon—Auxiliary Luncheon
Benjamin West Room, Thirteenth Fl.
1:00 p. m.—Tour of Exhibits
Lounge Floor
2:00 p. m.—General Session
Vernon Room, Lounge Floor
4:00 p. m.—Tour of Exhibits
Lounge Floor
8:30 p. m.—Reference Committees
Thirteenth Floor

WEDNESDAY, MAY 24, 1950

8:30 a. m.—Auxiliary Inaugural Breakfast
Mandarin Room, Thirteenth Floor
9:00 a. m.—Tour of Exhibits
Lounge Floor
10:00 a. m.—Auxiliary Executive Board
Mandarin Room, Thirteenth Floor
Scientific Sections:
General Practice
Vernon Room, Lounge Floor
Gastro-Enterology and Proctology
Rutland Room, First Floor
Chest Diseases
Benjamin West Room, Thirteenth Fl.
Clinical Pathology
Tower Room, Thirteenth Floor
12:00 noon—House of Delegates (Election)
Viking Room, Thirteenth Floor
1:00 p. m.—Tour of Exhibits
Lounge Floor
2:00 p. m.—House of Delegates
Viking Room, Thirteenth Floor
4:00 p. m.—Tour of Exhibits
Lounge Floor
5:00 p. m.—Registration and Exhibits Close
Lounge Floor
7:00 p. m.—Dinner-Dance
Vernon Room, Lounge Floor

THURSDAY, MAY 25, 1950

10:00 a. m.—Board of Trustees
Rowsley Room, First Floor

GENERAL SESSION

Tuesday Afternoon, May 23, 1950

2:00 p. m. — 4:00 p. m.
Vernon Room, Lounge Floor

JAMES F. NORTON, M.D., President, presiding

The American Medical Association and the Physician
Louis H. Bauer, M.D., Chairman, Board of Trustees, American Medical Association

Public Health and Medical Care
Honorable Alfred E. Driscoll, Governor of the State of New Jersey

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SCIENTIFIC SECTIONS

Monday Morning, May 22, 1950

10:00 a. m. — 12:00 noon

SURGERY

VICTOR B. SEIDLER, M.D., Chairman
V. EARL JOHNSON, M.D., Secretary
Vernon Room, Lounge Floor

10:00 a. m.
Surgical Lesions of the Stomach
Isidor S. Ravdin, M.D., Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia.
Discussors: Earl J. Halligan, M.D., Jersey City
Harry N. Comando, M.D., Newark

10:40 a. m.
Visit to Exhibits

11:00 a. m.
Lesions of the Colon
H. Wesley Jack, M.D., Chief of Surgery, West Jersey Hospital, Camden.
Discussors: Herbert A. Schulte, M.D., Newark
Lawrence G. Beisler, M.D., Hillside

11:25 a. m.
Differential Diagnosis of Jaundice
Frank W. Konzelmann, M.D., Director of Laboratories, Atlantic City Hospital, Atlantic City.
Discussors: William G. Bernhard, M.D., Short Hills
John L. Work, M.D., Montclair

11:50 a. m.
Business Session

PEDIATRICS

NORMAN T. CRANE, M.D., Chairman
MARTIN A. QUIRK, M.D., Secretary
Rutland Room, First Floor

10:00 a. m.
The Present Status of Hemolytic Disease of the Newborn
Philip Levine, M.D., Director, Rh Testing Laboratory, Ortho Research Foundation, Raritan.

10:30 a. m.
Business Session

10:45 a. m.
Visit to Exhibits

11:00 a. m.
Brain and Liver Injury in Erythroblastosis Fetalis
Richard Day, M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York.
Discussor: Robert E. Jennings, M.D., East Orange

11:30 a. m.
Pediatrics as Not in the Book
Charles Hendee Smith, M.D., New Brunswick, Emeritus Professor of Pediatrics, New York University College of Medicine, New York.

EYE, EAR, NOSE AND THROAT

A. M. K. Maldeis, M.D., Chairman
Albert F. Moriconi, M.D., Secretary
Viking Room, 13th Floor

10:00 a. m.
Consideration of Allergic Conditions from the Standpoint of the Otolaryngologist
Karl M. Houser, M.D., Professor of Otolaryngology, University of Pennsylvania School of Medicine, Philadelphia.
Discussor: Francis S. Weinstein, M.D., Newark

10:40 a. m.
Business Session

10:55 a. m.
Visit to Exhibits

11:15 a. m.
Removal of Intraocular Foreign Bodies by Anterior and Posterior Methods
A. Russell Sherman, M.D., Attending Surgeon, Ophthalmological Department, Eye and Ear Infirmary, Newark.
Discussors: James S. Shipman, M.D., Camden
Robison D. Harley, M.D., Atlantic City

Monday Afternoon, May 22, 1950

2:00 p. m. — 4:00 p. m.

MEDICINE

Jerome G. Kaufman, M.D., Chairman
Frank J. Altschul, M.D., Secretary
Vernon Room, Lounge Floor

2:00 p. m.
PANEL DISCUSSION
Recent Advances in Hematology
Lowell A. Erf, M.D., Moderator, Assistant Professor of Medicine, Jefferson Medical College, Philadelphia.
Panel: Lester M. Goldman, M.D., Newark
Frank W. Konzelmann, M.D., Atlantic City
Sylvan E. Moolten, M.D., New Brunswick
Carlos A. Pons, M.D., Asbury Park

3:00 p. m.
Visit to Exhibits

3:20 p. m.
Continuation of Panel Discussion

3:50 p. m.
Business Session

RADIOLOGY

Francis P. Carrigan, M.D., Chairman
Benjamin Copleman, M.D., Secretary
Viking Room, 13th Floor

2:00 p. m.
Early Diagnosis of Cancer of the Lung
Benjamin P. Potter, M.D., Chief, Division I, B. S. Pollak Hospital for Chest Diseases, Jersey City.
Discussor: Harry J. Perlberg, M.D., Jersey City

2:30 p. m.
Visit to Exhibits

2:50 p. m.
Radiological Treatment of Oral Cancer
William Harris, M.D., Radiotherapist, Mount Sinai Hospital, New York.

3:25 p. m.
Early Diagnosis of Cancer of the Stomach
Benjamin Copleman, M.D., Attending Roentgenologist, Perth Amboy General Hospital, Perth Amboy.
Discussor: Edward C. Klein, M.D., Newark

3:50 p. m.
Business Session

OBSTETRICS AND GYNECOLOGY

Hammell P. Shipps, M.D., Chairman
John D. Preece, M.D., Secretary
Rutland Room, First Floor

2:00 p. m.
The Management of Infection in Obstetrics and Gynecology
James F. Norton, M.D., Attending Obstetrician, Margaret Hague Maternity Hospital, Jersey City.
Discussor: Edward A. Y. Schellenger, M.D., Camden

2:30 p. m.
Anesthesia in Gynecological Surgery and Operative Obstetrics
Edward B. Tuohy, M.D., Professor of Anesthesiology, Georgetown University, Washington.
Discussor: Cornelius J. Regan, M.D., Camden

3:10 p. m.
Business Session and Visit to Exhibits

3:30 p. m.
Management of Breech Delivery
Herbert Johnson, M.D., Associate Obstetrician, The Cooper Hospital, Camden.
Discussor: Robert A. MacKenzie, M.D., Asbury Park

Wednesday Morning, May 24, 1950

10:00 a. m. — 12 noon

GENERAL PRACTICE

AARON H. HORLAND, M.D., Chairman
D. WARD SCANLAN, M.D., Secretary
Vernon Room, Lounge Floor

10:00 a. m.

Business Session

10:15 a. m.

Visit to Exhibits

10:30 a. m.

Heart Disease and the General Practitioner
William D. Stroud, M.D., Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.
Discussors: Jerome G. Kaufman, M.D., Newark
Thomas J. White, M.D., Jersey City

11:00 a. m.

The General Practitioner, His Place in 1950 Medicine
Aaron H. Horland, M.D., President, New Jersey Academy of General Practice, Newark.
Discussors: Samuel L. Kaman, M.D., Atlantic City
D. Ward Scanlan, M.D., Atlantic City

11:30 a. m.

Treatment of Rheumatoid Arthritis in General Practice
Herman H. Tillis, M.D., Chief of Arthritis, Presbyterian Hospital, Newark.
Discussors: Harold S. Connamacher, M.D., Newark
Clarence B. Whims, M.D., Atlantic City

CLINICAL PATHOLOGY

WILLIAM G. BERNHARD, M.D., Chairman
WILLIAM W. HERSOHN, M.D., Secretary
Tower Room, 13th Floor

10:00 a. m.

Evaluation of Certain Hematological Procedures
Murray W. Shulman, M.D., Director of Laboratories, Veterans Administration, Newark.
Discussor: Samuel A. Goldberg, M.D., Newark

10:25 a. m.

Carcinoma of the Breast, Certain Aspects of a Five Year Experience in a General Hospital
John L. Work, M.D., Attending Pathologist, The Mountainside Hospital, Montclair.
Discussor: Arturo R. Casilli, M.D., Elizabeth

10:50 a. m.

Visit to Exhibits

11:10 a. m.

The Role of Pathology in Lesions of the Breast.
Arthur Purdy Stout, M.D., Professor of Surgery, College of Physicians and Surgeons, Columbia University, New York.
Discussor: A. Hobson Davis, M.D., Paterson

11:45 a. m.

Business Session

GASTRO-ENTEROLOGY AND PROCTOLOGY

SYDNEY ROSENTHAL, M.D., Chairman
FRANK S. FORTE, M.D., Secretary
Rutland Room, First Floor

10:00 a. m.

The Problem of Malignancy in Gastric Ulcer
Louis L. Perkel, M.D., Gastro-Enterologist, Medical Center, Jersey City.
Co-Author: Leonard Troast, M.D., Assistant Attending Physician, Medical Center, Jersey City.
Discussor: S. Bernard Kaplan, M.D., Newark

10.30 a. m.

Business Session

10:40 a. m.

The Management of Massive Hemorrhage from the Upper Gastro-intestinal Tract
Henry J. Tumen, M.D., Associate Professor in Gastro-Enterology, Graduate Hospital, University of Pennsylvania, Philadelphia.
Discussor: Sigurd W. Johnsen, M.D., Passaic

11:10 a. m.

Visit to Exhibits

11:30 a. m.

Modern Concepts in the Treatment of Fistula in Ano
George L. Becker, M.D., Paterson, Attending Proctologist, Midtown Hospital, New York.
Discussor: Johannes F. Pessel, M.D., Trenton

CHEST DISEASES

JUAN R. HERRADORA, M.D., Chairman
PAUL K. BORNSTEIN, M.D., Secretary
Benjamin West Room, 13th Floor

10:00 a. m.

Extrapleural Pulmonary Resection—Evaluation of a New Procedure
Irving J. Selikoff, M.D., Paterson, Associate Attending Physician, Sea View Hospital, Staten Island.
Discussor: Frank Bortone, M.D., Jersey City

10:25 a. m.

Interesting Cases of Chest Pathology
Harrison S. Martland, M.D., Chief Medical Examiner of Essex County, Newark.
Discussor: Irving L. Applebaum, M.D., Newark

10:50 a. m.

Business Session

11:05 a. m.

Visit to Exhibits

11:25 a. m.

X-Ray Conference—Cases of unusual interest diagnosed by panel of four chest physicians and discussed by audience.
Merrill C. Sosman, M.D., Moderator, Professor of Radiology, Harvard Medical School, Boston.

HOUSE OF DELEGATES

Presiding Officer, James F. Norton, M.D., President, Jersey City
Secretary, Marcus H. Greifinger, M.D., Newark

Sergeants-at-Arms: Benjamin F. Lee, M.D., Camden
R. John Cottone, M.D., Trenton

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Viking Room, 13th Floor

First Session: 10:00 a. m., Tuesday, May 23, 1950

Order of Business

a. Call to Order
b. Organization of House of Delegates
c. Minutes of 1949 Meeting
d. Introduction of Delegates from Other States
e. Annual and Supplemental Reports
f. Award to Outstanding General Practitioner for 1950
g. Announcements

Second Session: 12:00 noon, Wednesday, May 24, 1950

Order of Business

a. Report of Nominating Committee
b. Election

Third Session: 2:00 p. m., Wednesday, May 24, 1950

Order of Business

a. Reports of Reference Committees
b. Unfinished Business
c. Installation of Incoming President
d. Adjournment

REFERENCE COMMITTEES

Tuesday Evening, May 23, 1950, 8:30 p. m.
Thirteenth Floor

Reference Committee "A", to consider reports of:
The President
The Board of Trustees
The Secretary
The Judicial Council
The Executive Officer

Reference Committee "B", to consider reports of:
The Treasurer
The Finance and Budget Committee
The Publication Committee

Reference Committee "C", to consider reports of:
The Medical Service Administration
The Medical-Surgical Plan
The Emergency Medical Services Committee
The Veterans Liaison Committee
The Military Service Committee
The Emergency Education Program Committee

Reference Committee "D", to consider reports of:
The Medical Education Committee
The Scientific Work Committee
The Medical Defense and Insurance Committee
The Advisory Committee to the Woman's Auxiliary
The State Board of Medical Examiners
The New Jersey Health Congress

Reference Committee "E", to consider reports of:
The Welfare Committee
The Subcommittees of the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee

Reference Committee on Constitution and By-Laws, to consider:
Amendments to the Constitution
Amendments to the By-Laws

Reference Committee on Miscellaneous Business, to consider also reports of:
The Annual Meeting Committee
The Subcommittee on Scientific Program
The Subcommittee on Scientific Exhibits
The Place and Dates for the 1951 Annual Meeting

Reference Committee on Resolutions and Memorials, to consider also reports of:
The Committee on Honorary Membership
Nominations for Emeritus Membership

Reference Committee on Credentials
Meets at Registration Desk each morning of the meeting.

DINNER DANCE

in honor of

PRESIDENT AND MRS. JAMES F. NORTON

Wednesday Evening, May 24, 1950

Vernon Room, Lounge Floor

7:00 p. m.

Toastmaster: Dr. Joseph P. Donnelly

Welcome: Mrs. Norman Nathanson, President, Woman's Auxiliary
Dr. James F. Norton, President

Introductions: Mrs. R. John Cottone, President-Elect, Woman's Auxiliary
Dr. Aldrich C. Crowe, President-Elect

Presentation of Fellow's Key:
To: Dr. James F. Norton, President
By: Dr. J. Howard Hornberger, Immediate Past-President

Entertainment:
The Doctors' Chorus of the Essex County Medical Society
Carl Wieseman, Mus.D., Director
Edwin A. Seidman, M.D., Accompanist

Music:
Joseph Sterns' Orchestra

SPECIAL EVENTS

MONDAY, MAY 22, 1950

12:00 noon—Luncheon, New Jersey Medical Women's Association
Room 1334, Thirteenth Floor

TUESDAY, MAY 23, 1950

4:30 p. m.—Medical Advisory Committee to New Jersey League for Planned Parenthood
Room 1334, Thirteenth Floor

WEDNESDAY, MAY 24, 1950

9:00 a.m.—New Jersey Academy of General Practice
Vernon Room, Lounge Floor

WOMAN'S AUXILIARY
to
THE MEDICAL SOCIETY OF NEW JERSEY
TWENTY-THIRD ANNUAL MEETING

Monday, May 22, 1950

10:00 a. m.—Registration, Luncheon and Dinner Tickets
Lounge Floor

1:00 p. m.—Panel Discussion
Mandarin Room, Thirteenth Floor

1. Relationship Between The Medical Society and the Auxiliary in the Field of Public Relations.
2. Current Legislative Problems and How to Get the Job Done.
3. 1-10-20 Plan and Current Voluntary Health Plans in New Jersey.
4. Look! Your Programs are Showing.
5. What is Wrong With the Auxiliary? These panels to be made up from members of the Auxiliary and Medical Society representatives.

3:30 p. m.—Informal tea
Tower Room, Thirteenth Floor
All physicians' wives cordially invited

6:30 p. m.—Fellowettes' Dinner (by invitation only)
Mandarin Room, Thirteenth Floor

Tuesday, May 23, 1950

9:30 a. m.—General Session
Mandarin Room, Thirteenth Floor

Order of Business:

1. Invocation

2. Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association: Mrs. Robert B. Walker, Immediate Past-President
3. Welcome: Mrs. Louis Rosenberg, President, Woman's Auxiliary to the Atlantic County Medical Society
4. Response: Mrs. R. John Cottone, President-Elect
5. Presentation of Convention Chairmen, Mrs. Harry Subin
6. Introductions
7. Presentation of President-Elect: Mrs. R. John Cottone
8. Roll Call
9. Minutes of 22nd Annual Meeting
10. Convention Rules of Order
11. Credentials and Registration: Mrs. Pascal J. Baiocchi
12. Address of President: Mrs. Norman Nathanson
13. Reports
    Annual Reports of State Officers, State Chairmen and County Presidents will be distributed in booklet form to convention audience.
14. Convention Announcements
15. In Memoriam: Mrs. George A. Rogers
16. Resolutions: Mrs. Stewart F. Alexander
17. Unfinished Business
18. New Business
19. Report of Nominating Committee: Mrs. Robert B. Walker
20. Election of Officers
21. Guest Speaker: Mrs. David B. Allman, President, Woman's Auxiliary to the American Medical Association

12:00 noon—Luncheon honoring Mrs. Norman Nathanson, President
Benjamin West Room, Thirteenth Fl.

Toastmistress: Mrs. Asher Yaguda

Welcome: Mrs. Norman Nathanson, President

Greetings: James F. Norton, M.D., President, The Medical Society of New Jersey

Guest Speaker: Professor Richard C. Reager, Rutgers University "The Doctor's Wife Can Speak Well Too"

Presentation of President's Pin:
To: Mrs. Norman Nathanson, President
By: Mrs. Robert B. Walker, Junior Past -President

2:00 p.m.—Medical Society General Session
Vernon Room, Lounge Floor

All physicians' wives cordially invited to attend.

Wednesday, May 24, 1950

8:30 a.m.—Inaugural Breakfast
Mandarin Room, Thirteenth Floor

10:00 a.m.—Post-Convention Board Meeting
Mandarin Room, Thirteenth Floor

Guest Speaker: Aldrich C. Crowe, M.D., Incoming President of The Medical Society of New Jersey

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge Floor

SCIENTIFIC EXHIBITS

Lounge Floor

Booth 1—Constrictive Pericarditis — Henry A. Brodkin, M.D., and Marvin C. Becker, M.D., Beth Israel Hospital, Newark.

An exhibit which demonstrates a condition amenable to surgical cure, though it often masquerades under the diagnosis of congestive heart failure or cirrhosis of the liver. The exhibit highlights the diagnostic criteria and the surgical approach to the problem. It is liberally illustrated with photographs and graphs.

Booth 2 — Precordial Electrocardiographic Technic — A. M. Lyle, F.S.A., Charles E. Klessling, M.D., H. B. Kirkland, M.D., The Prudential Insurance Company of America, Newark.

This exhibit is designed to show the electrocardiographic findings in precordial leads made with the various technics, (CR, CL, and CF) and to compare and contrast them with the V leads. The diagnostic advantages of a full set of six precordial leads are illustrated by cases showing abnormalities that would not have been detected by a single lead at the apex, and by cases in which the apex lead is abnormal but the additional precordial leads make possible a more complete diagnosis. The importance of the location of the precordial electrode is demonstrated.

Booth 3—Simplified Diagnosis of Congenital Heart Disease—Henry Borow, M.D., Bound Brook, and Vincent J. Felitti, M.D., North Bergen, Bound Brook Hospital, Bound Brook, N. J.

Models representing congenital defects of the heart are so placed behind screens that they cast shadows similar to shadows on the fluoroscopic screen. Charts and drawings deal with the clinical differential diagnosis of the various lesions. The cardiac models include the normal heart, patent ductus arteriosus, large patent interventricular septum, transposition of great vessels, Eisenmenger complex, tricuspid stenosis, truncus arteriosus, tetralogy of Fallot, patent interventricular septum and coarctation of aorta.

Booth 4—Angiocardiography—William A. Leff, M.D., and Nathan J. Furst, M.D., Newark.

X-ray presentation of angiocardiograms showing the normal filling of the chambers of the heart

and great vessels. Short case histories and angiocardiograms of congenital heart disease, tumors of the mediastinum in relation to the heart and major blood vessels; bronchogenic carcinoma in relation to pulmonary arteries, syphilitic heart disease (aneurysms—valvular lesions—effect on pulmonary arteries—aortitis, et cetera). Congenital anomalies of pulmonary arteries and vena cava.

Booth 5—Malignant Lesions of the Left Lobe of Liver, (Roentgen Manifestations) — Raphael Pomeranz, M.D., Newark.

Thirty-six transparencies demonstrating clinical, x-ray, gross and microscopic studies of neoplasms of the liver with particular attention to the left lobe. Motility gastro-intestinal studies and "selective barium residue" serve as a clue in diagnosis.

Booth 6—Variations of the Normal Intestinal Bacteria in Specific and Nonspecific Conditions of the Colon — Harry Seneca, M.D., and Edward Henderson, M.D., Schering Corporation, Bloomfield, and Columbia University, New York. Shown here are: (1) Total intestinal bacteria in normal individuals; (2) changes in the normal intestinal bacteria in (a) transplantations of ureter in sigmoid, (b) ulcerative and mucous colitis, (c) streptococcus colitis, (d) amebic colitis and (e) coeliac syndrome; and (3) sterilization of the gut with thalamyd.

Booth 7—Peri-Anal Infections in Tuberculous Patients (Diagnosis and Surgical Treatment)—Julius Gerendasy, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City.

A classification of the more common infectious anal lesions found in tuberculous patients is presented. The exhibit shows the origin and development and specific clinical characteristics of tuberculous perianal infections. Illustrations of tuberculous and non-tuberculous perianal lesions are presented. Surgical therapy and the progress of healing at various stages are emphasized.

Booth 8—Massive Hemorrhage from Upper Gastro-Intestinal Tract — Earl J. Halligan, M.D., Medical Center, Jersey City.

Booth 9—Malignancy in Gastric Ulcer—Louis L. Perkel, M.D., and Leonard Troast, M.D., Medical Center, Jersey City.

Transparencies demonstrate the difficulty in differentiating "benign" from "malignant" gastric ulcer. Examples are shown of the healing of a large ulcer which was thought to be malignant and conversely the finding of a malignancy in a small ulcer thought to be benign. Also demonstrated are examples of hour-glass stomach due to gastric ulcer as well as ulcer craters of various sizes and in various locations in the stomach.

Booth 10—Diseases of the Anus, Rectum and Sigmoid: Diagnosis and Treatment — Edwin H. Albano, M.D., and Arthur Giffoniello, M.D., Columbus Hospital, Newark.

This display includes mannikin (life-size) with procto-sigmoidoscopic illustrations of various anorectal-sigmoidal lesions; gross specimens of rectosigmoidal cancer; demonstration of new plastic preservation of gross specimens; photographs illustrating Papanicolaou smears of rectal cancer; and demonstration of Papanicolaou staining technic.

Booth 11—Obstetrical Injuries to Epiphyses of Long Bones—Spencer T. Snedecor, M.D., and Harrison B. English, M.D., Hackensack Hospital, Hackensack.

Booth 12—Blood Volume in Surgery—C. Abbott Beling, M.D., William G. Bernhard, M.D., George L. Erdman, M.D., Donald T. Bosch, M.D., Thomas V. Morton, Jr., M.D., Robert I. Siegel, M.D., Ladislav Stefan, M.D., Eleanor Bonner, B.A., Hospital of St. Barnabas, Newark.

Blood volume determinations are necessary for proper evaluation of surgical risk; are easy to do even in small hospitals and provide reasonably accurate guides to quantitative replacement of deficits. Such replacement increases the scope of surgery and lessens mortality. The clinical bases of the above are presented, with the technic of the procedure both at the bedside and in the laboratory.

Booth 13—Fate of Human Tissue Grafts Transplanted in Humans—Lyndon A. Peer, M.D., and John C. Walker, M.D., Newark.

Charts and micro-photographs showing what happens to autogenous tissue grafts in contrast with unlike tissue. Tissues demonstrated include: muscle, fat, bone, cartilage, skin, fascia, nerve and tendon.

Booth 14—The General Practice of Medicine and Surgery 1950 — Aaron H. Horland, M.D., President, and Edwin Rosner, M.D., Secretary-Treasurer, New Jersey Academy of General Practice.

Posters and diagrams depicting the history of the general practice of medicine. Charts show the distribution of general practitioners in U. S. and in N. J.; hospitals having G. P. sections; technic of establishing a G. P. section in a hospital; the relation of the G. P. to the hospital and to the specialist; and facts about graduate instruction for the G. P. in New Jersey.

Booth 15—The Rehabilitation of the Severely Handicapped—Henry H. Kessler, M.D., Medical Director, Kessler Institute for Rehabilitation, West Orange.

Demonstration by amputees, exhibit of photographs showing technics of training amputees, paraplegics, hemiplegics, post-poliomyelitis cases, and neuro-muscular disabilities. Display of professional literature.

Booth 16—Primary Carcinoma of Lung—Peter Gianquinto, M. D., William G. Bernhard, M.D., A Leone, M.D., and L. Stefan, M.D., Hospital of St Barnabas and For Women and Children, Newark.

The exhibit includes radiographs of primary carcinoma of lung with respect to radiographic diagnoses. This is accompanied by the relevant pathologic material, both gross and histologic. Stress is placed on "suspicion" and early diagnosis of carcinoma of lung, the incidence of which has shown a definite and real increase in recent years

Booth 17—Micro Organisms Associated With Proliferative Disease—Virginia Wuerthele-Caspe, M.D., Roy Allen, D.S., James Hillier, Ph.D., L. W. Smith, Ph.D., Elinore Alexander-Jackson, Ph.D., John A. Anderson, Ph.D., Marilyn Clark and Emma Lampe, Presbyterian Branch of the Bureau of Biological Research, Rutgers University, Studies of Proliferative Diseases, Newark.

This exhibit represents a study of a class of plemorphic, filtrable, acid-fast micro-organisms isolated from various proliferative diseases, including neoplasms, of man and animals. Their morphology, staining characteristics, cultural properties, and pathogenicity for experimental animals are presented. Light and electron microscope studies have been done of both the filtrable and non-filtrable forms.

Booth 18—Hyaluronidase in Medicine—Clair E. Fulsome, M.D., and H. O. Singher, Ph.D., Ortho Research Foundation, Raritan.

Charts, photographs and photomicrographs illustrate the application of hyaluronidase in hypodermoclysis, regional anaesthesia, pyelography and the more rapid subcutaneous administration of selected pharmacologic agents.

Booth 19—Cytologic Diagnosis — Nicholas M. Alter, M.D., R. Chesley, Edward Sattenspiel, M.D., W. Berkhofer, F. Traugott, Margaret Hague Maternity Hospital, Jersey City.

This exhibit is based on about 10,000 cases studied since 1945. Three groups are included: (a) functional changes, (b) uterine carcinoma, and (c) miscellaneous: lung carcinoma, fluids, breast, et cetera.

Booth 20—Diagnostic Tests in Endocrinopathies—H. S. Kupperman, M.D., Arthur Bernstein, M.D., Emanuel Klosk, M.D., Franklin Simon, M.D., Sol Parent, M.D., A Silver, M.D., Henry Green, M.D., Jay Burger, Newark Clinical Group, Department of Internal Medicine, Newark.

A description and discussion of the tests used in the differential diagnosis of diseases of the glands of internal secretion. The detail of various technics employed in the endocrine diagnostic laboratory is presented in slides and pictures.

Booth 21—Carbohydrate Metabolism in Endocrine Disturbances—Rita S. Finkler, M.D., and George M. Cohn, M.D., Newark Beth Israel Hospital, Newark.

In the consideration of any endocrinologic dysfunction, evaluation of the carbohydrate metabolism is of importance. In most cases, there is a concomitant disturbance of carbohydrate metabolism.

The material in this exhibit shows non-pancreatic disturbances of carbohydrate metabolism and their response to therapy. The following conditions are presented: (a) pituitary diseases including tumors, (b) hypothalamic disturbances, (c) thyroid diseases consisting of hypothyroid and hyperthyroid states, (d) disturbances of adrenal function and (e) disturbances of ovarian and testicular function.

Booth 22—Lesions of the Endocrine System—Samuel A. Goldberg, M.D., Presbyterian Hospital, Newark.

The exhibit consists of colored kodachrome and black-and-white transparencies of gross and microscopic sections of the organs of the endocrine system, particularly the ovaries, testes, thyroid, and adrenals.

Booth 23—Liver Hyperglycemia and Glycosuria—Carroll M. Leevy, M.D., Jacob C. Fineberg, M.D., Thomas J. White, M.D., Angelo M. Gnassi, M.D., Medical Center, Jersey City.

Persistent hyperglycemia and glycosuria have multiple causes. Liver abnormalities may cause persistent hyperglycemia and glycosuria. Thus it is desirable to recognize this state and control the carbohydrate disturbances with hepatotherapy. Observations on seven such patients followed from two to five years have been analyzed to evaluate diagnostic criteria, therapeutic approaches and complications of liver hyperglycemia and glycosuria.

History, physical examination, biochemical liver function studies, needle biopsy of the liver and therapeutic response were used to assay the relation of the hepatic and carbohydrate disturbances. Criteria for a diagnosis of liver hyperglycemia and glycosuria included: (a) history of nutritional deficiency, alcoholism or exposure to hepatotoxins prior to the appearance of the diabetic syndrome; (b) physical, biochemical and histologic evidence of liver disease; (c) persistent hyperglycemia and glycosuria with or without symptoms: (d) hepatotherapy without insulin leading to simultaneous disappearance of carbohydrate intolerance and improvement of the hepatic abnormality, or the demonstration of insulin resistance; (e) absent familial history of diabetes and no history or clinical evidence of pancreatic, pituitary, adrenal or thyroid disease.

Liver hyperglycemia and glycosuria may be due to: (1) latent pancreatic deficiency and relative insulin insufficiency made overt by the liver disease. (2) the toxic or nutritional factors responsible for the hepatic injury may have also produced a pancreatic lesion and insulin insufficiency corrected by removal of the noxious agent. (3) fat or fibrosis of the liver might anatomically interfere with glycogen storage, preventing normal homeostasis of blood sugar. (4) increased excretion, destruction or inhibition of insulin or a biochemical lesion which interferes with phosphorylation. These mechanisms are discussed on basis of observations on the presented patients.

Booth 24—Diagnosis of Generalized Amyloidosis: Diagnostic Technics and Criteria—Irving J. Selikoff, M.D., Paterson.

Booth 25—Congenital Heart Disease, Diagnosis and Treatment—Harrold A. Murray, M.D., William Rumsey, M.D., Charles Bailey, M.D., Daniel F. Downing, M.D., Pediatric Department, St. Michael's Hospital, Newark.

This exhibit lists two types of congenital heart disease which are being treated at St. Michael's Surgical-Cardiac Clinic and gives diagnostic criteria for each type. Special attention is given to the indications for angiocardiography, aortography, and catheterization of the heart.

A simple, inexpensive method of rapidly changing casettes is presented, together with the equipment necessary for aortography and angiocardiography. X-rays of typical cases are demonstrated.

TECHNICAL EXHIBITS

Lounge Floor

Booth 1—Lederle Laboratories, New York, N. Y.—You are cordially invited to visit our exhibit where you will find representatives who are prepared to give you the latest information on Lederle products.

Booth 2—Buffington's, Inc., Worcester, Mass.—Buffington Professional Representatives will be in attendance to discuss with visiting physicians, the various aspects of some of the newer Buffington products. Particular attention will be given to *Trigelma-H.M., Trand, Cal-Bo-Tab Ferrous, Higadoce* and *Kestrone-E.*

Booth 3—L. & B. Reiner, Inc., New York, N. Y.—L. & B. Reiner, Inc., of 139 East 23rd St., New York City, will exhibit in Booth 3 the latest type of Basal Metabolism Apparatus. This new Jones *Multi-Basal* is tailor made to your patient and is a revelation in B.M.R. Machines. Also on display will be the *Cardiotron* Direct-Writing E.K.G., the first and only one with features that no other machine has. We will welcome the opportunity of demonstrating these units to you.

Booth 4—The Kelley-Koett Manufacturing Co., Covington, Kentucky — Keleket, the oldest original name in X-ray extends a cordial invitation to visit their Booth 4. On display is the new American Electric Pediatricians Table Unit, and Keleket K-30 Fluoroscope with Ortho-diagraphic attachment. Also available for your inspection will be recently designed medical X-ray accessories and supplies. Courteous Keleket representatives will be in attendance.

Booth 5—Camel Cigarettes, New York, N. Y.—*Camel* Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking *Camel* Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking *Camels*".

Booth 6—Doho Chemical Corporation, New York, N. Y.—The Doho Chemical Corporation and its subsidiary, Mallon Chemical Corporation, makers of *Auralgan, O-Tos-Mo-San,* and *Rectolgan,* are proud to announce their new nasal decongestant, *Rhinalgan*—a balanced formulation of two active chemical compounds that gives prolonged vasoconstriction—used as a spray in our patented Dohony Spray-O-Mizer (combination dropper and spray)—pleasant tasting, with no systemic effect (pressor or respiratory), and can be safely used for infants and children.

Our representatives are anxious to explain the merits of *Rhinalgan* and distribute samples of this new innovation.

Booth 7—Smith, Kline & French Laboratories, Phila, Pa.—*'Dexamyl'*—S.K.F.'s balanced combination of *'Dexedrine'* Sulfate (dextro-amphetamine sulfate, S.K.F.) and *'Amytal'* (Amobarbital, Lilly)—is a new preparation of wide usefulness in everyday practice. Combined in *'Dexamyl', 'Dexedrine'* and *'Amytal'* work together to provide symptomatic relief from mental and emotional distress.

Booth 8—Merck & Company, Inc., Rahway, N. J.—*Benodaine,** a diagnostic agent of value for detecting hypertension caused by the presence of an epinephrine-producing tumor (pheochromocytoma); *Cobione*R (Crystalline Vitamin B-12 *Merck*) for the treatment of megaloblastic anemias; *Neo-Antergan*R, an anti-histaminic agent which is advertised to the medical profession exclusively; *Pas* (Para-Aminosalicylic Acid *Merck*) for complementing streptomycin and dihydrostreptomycin in tuberculosis therapy; and *Urecholine*R, for relieving urinary retention, gastric retention and abdominal distention.

*"*Benodaine*" is the trade-mark of *Merck & Co., Inc.*, for its brand of piperoxane.

Booth 9—Sandoz Chemical Works, Inc., New York, N. Y.—Physicians attending The Medical Society of New Jersey Convention are cordially invited to visit the Sandoz Pharmaceuticals display which will feature the following:

Cafergone—the first effective oral preparation for the treatment of migraine and related headaches.

Bellergal—a time-tested preparation for use in functional disorders.

Other products displayed at this convention are *Belladonal, Mesantoin, Dihydroergotamine—D.H.E.* 45 and *Ipesandrine.*

A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

Booths 10-11—Picker X-Ray Corporation, New York, N. Y.—Picker X-Ray Corporation will exhibit the new practical x-ray unit at a popular price—*The Meteor.* A patented tilting table top feature provides for rapid and easy conversion from radiography to fluoroscopy in either horizontal or vertical positions.

Booth 12—Mead Johnson & Company, Evansville, Indiana—*Dextri-Maltose, Oleum Percomorphum, Pablum, Pabena, Olac* and other Mead products used in Infant Nutrition will be on display at the Mead Johnson Exhibit at your Medical Society of New Jersey Meeting. *Protenum,* a new high protein product, will be displayed. Also, *Lonalac,* for low sodium diets. Our representatives at the Exhibit will be glad to discuss with you the new improvements of *Amigen* and *Amiscts.*

Booth 13—Ayerst, McKenna & Harrison, Ltd., New York, N. Y.—*"Premarin"* (Estrogenic Substances — water-soluble) — a highly effective and well-tolerated preparation of naturally-occurring, orally-active, conjugated estrogens (equine). The potency of *"Premarin"* is expressed in terms of its principal estrogen, sodium estrone sulfate.

"Premarin" provides convenience of administration and flexibility of dosage. Four potencies of *"Premarin"* Tablets are available. *"Premarin"* is also presented in liquid form.

Booth 14—Hanovia Chemical and Manufacturing Company, Newark, N. J.—Hanovia will display and demonstrate new Short Wave Diathermy

machines, self-lighting ultraviolet lamps for orificial and body irradiation, Sollux radiant heat lamps, Germicidal lamps and black light for diagnostic purposes.

Booth 15—E. & W. Blanksteen, Jersey City, N. J.—The State Society's plan of accident and health insurance for its members, underwritten by the National Casualty Company of Detroit through the State Society's brokers, E. & W. Blanksteen, 75 Montgomery Street, Jersey City 2, N. J., has again been improved by the Company, *at no additional cost* to the doctor—policyholder. Sickness benefits have been extended from twelve months for any one sickness to twenty-four months; accident benefits are payable for as long as five years for any one accident so long as the doctor is unable to perform the duties of his profession. It is suggested that you read the annual report of the Committee on Medical Defense and Insurance on the subject of accident and health insurance.

Booth 16—Faulhaber & Heard, Inc., Newark, N. J.—Full particulars can be obtained on the special Professional Liability contract available to members of The Medical Society of New Jersey upon inquiry at the booth of the Official Broker, Faulhaber & Heard, Inc., No. 16. Should there be any member who is not carring the official policy it is advisable for him to take advantage of this important feature of his membership.

Booth 17—Carnation Company, Los Angeles, California—You are invited to visit the Carnation Company booth, No. 17, where you will see an attractive display presenting some interesting information on the various uses of Carnation Vitamin D Evaporated Milk for infant feeding, child feeding and general diet purposes. The method by which Carnation Milk is so generously fortified with Vitamin D—400 U.S.P. Units per reconstituted quart—will be explained. Valuable literature will also be available for distribution.

Booth 18—Ortho Pharmaceutical Corporation, Raritan, N. J.—Ortho cordially invites you to Booth 18 where their complete line of gynecic pharmaceuticals will be exhibited. Featured will be the new Ortho White Flat Spring Diaphragm; the Ortho Kit, a modern convenient kit of essential materials for conception control; and Massé Nipple Cream for the treatment and prevention of cracked nipples.

Booth 19—M & R Dietetic Laboratories, Inc., Columbus, Ohio—Similac Division, M & R Dietetic Laboratories, Inc., will display *Similac*, a food for infants, and *Cerevim*, a cereal food. Our representatives will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

Booth 20—Baldwin Pharmacal Co., Inc., Newark, N. J.—Several of the latest specialties for prescription use will be exhibited. These include preparations for the treatment of atherosclerosis, impaired liver function, liver damage, impaired metabolism, hypercholesterolemia also products for hypertension, arthritis and a new approach in the management of fungus infections.

Samples of all the preparations will be available.

A souvenir of the convention will be sent to all physicians who register with us at our exhibit.

Booth 21—Gerber Products Company, Fremont, Michigan — Is it baby feeding or babying adults' alimentary tracts? Either or both—we can serve you with a COMPLETE line of good-to-eat Strained and Junior foods PLUS new editions of baby care books. The 1950 Special Diet Recipes is nutritionist edited for smooth diet simplification and palatability. We are on the exhibit floor to greet you.

Booth 22—Pet Milk Sales Corporation, St. Louis, Mo.

Booth 23—W. B. Saunders Company, Philadelphia, Pa.—We invite the doctors attending the meeting of The New Jersey Medical Society to visit our exhibit where Mr. William Burns will display a complete line of our books including Hyman's "Integrated Practice of Medicine", Bockus' "Postgraduate Gastroenterology", "Cytologic Diagnosis of Cancer", Wells' "Clinical Pathology", Wolff's "Electrocardiography", Conn's "1950 Current Therapy", Mitchell and Nelson's "Pediatrics", Hauser's "Diseases of the Foot", Nesselrod's "Proctology", Custer's "Atlas of Blood and Bone Marrow", Sunderman and Boerner's "Normal Clinical Values", Friedberg's "Diseases of the Heart", Dry's "Cardiology", Janney's "Medical Gynecology", Levine and Harvey's "Clinical Auscultation of the Heart", and many other new books and new editions.

Booth 24—Borden Company, New York, N. Y.—Borden's *Infose* brand syrup for infants is a concentrate of selected apple juice standardized for pectin and partially neutralized, for milk modification. A completely natural product containing the naturally-occurring sugars, *Infose* supplies pectin and available organic iron in one convenient source for the infant's formula. Ask for complete data at this booth.

Booth 25—Holland-Rantos Company, Inc., New York, N. Y.—The H-R exhibit will feature Council-accepted *Koromex Products* for conception control. See the different combination sets, the anatomically-correct Pelviform Clinical Teaching Model and *H-R Lubricating Jelly* for gynecologic and surgical use. Investigate the effectiveness and practicability of *Nylmerate Jelly* in the treatment of vaginal trichomoniasis and monilasis.

Booth 26—Saratoga Spa, Saratoga Springs, N. Y.—This exhibit consists of a new knotty pine display emphasizing treatments with use of naturally carbonated mineral water at the New York State-owned Saratoga Spa at Saratoga Springs, N. Y. Recreational features are also described. Literature will be available and an attendant will serve Geyser water throughout exhibit hours.

Booth 27—U. S. Vitamin Corp., New York, N. Y.

Booth 28—Doak Company, Inc., Hyattsville, Md.—Doak Company exhibits nationally recognized dermatological preparations among which are:

Buro-Sol Powder (Doak—Soluble Powder Aluminum Acetate),—Antiphlogistic and Astringent wet application or compress. Teaspoonful of *Buro-Sol Powder* dissolved in a pint of water or milk is therapeutically equivalent to 1:15 Burow's Solution.

Buro-Sol Cream (Doak),—a greaseless and astringent and antiphlogistic cream containing 1% *Buro-Sol Powder* is also therapeutically equivalent to 1:15 Burow's Solution.

Pasta Duret (Doak),—a semi-greaseless cream containing chemically inter-reacted coal tar, sulfur, camphor and chaulmoogra oil. Favorably reported by University of Paris in treatment of neurodermatitis and eczematoid dermatitis.

Normaderm (Doak),—greaseless cream with pH of 3.5, containing buffered lactic acid. A useful application in combating housewife's dermatitis, dish-pan hands and dry eczema due to the excessive use of alkaline washing powders and hard soaps.

Tersus—an effective skin and scalp cleanser with constant pH of 6.8. *Tersus* now contains highly germicidal quaternary ammonia compound. Indicated in all cases intolerant to soaps, eczematoid dermatitis and acne.

Booth 29—E. R. Squibb & Sons, New York, N. Y.

Booth 30—Wyeth Incorporated, Philadelphia, Pa. — *Membrettes*—buccal tablets of various sex hormones for sublingual absorption and *S.M.A.*—the standard, council-accepted complete food formula for infants will be featured along with such widely prescribed ethical specialties as *Tubex, Kaomagma* with *Pectin, Hydase, Amphojel, Pondets, Meonine.* Trained representatives will be on hand to supply literature and samples of many other outstanding therapeutic agents.

Booth 31—Eli Lilly and Company, Indianapolis, Indiana—Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Space No. 31. The display for 1950 features a presentation on the incidence and potential number of diabetics in America. The attending representatives will be pleased indeed to assist visiting physicians in every way possible.

Booth 32—Philip Morris & Co., Ltd., Inc., New York, N. Y.—Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that *Philip Morris* are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Booth 33—Schering Corporation, Bloomfield, N. J.—*Buccal Tablets* of *Oreton, Progynon, Proluton,* and *Cortate* with the exclusively new base, Polyhydrol, will be featured at the Schering exhibit. Polyhydrol makes possible complete absorption of hormones via the buccal route providing advantages of high effectiveness, convenience, and economy. *Trimeton* and *Chlor-Trimeton,* two outstanding antihistamines, and *Coricidin,* Schering's new treatment for the common cold, containing Chlor-Trimeton, aspirin, phenacetin, and caffeine, will highlight the exhibit.

Schering Representatives will be present to welcome you, and will be happy to answer inquiries concerning Schering's new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

Booth 34—Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.—"B. W. & Co." will feature a completely new type antihistaminic, *Perazil* brand Chlorcyclizine Hydrochloride. *Perazil* differs chemically in that it is a piperazine, rather than a conventional ethylenediamine compound. Ask our representatives about the advantages of *Perazil.* We will also feature *Wellcome* brand *Globin Insulin,* the accepted intermediate acting insulin, and *Digoxin,* for safe, predictable digitalization.

Booth 35—Bristol-Myers Company, New York, N. Y.—Professional representatives will be in attendance at Bristol-Myers' booth to answer any questions regarding *Bufferin, Sal Hepatica* and other well-known Bristol-Meyers products.

Booth 36—White Laboratories, Inc., Newark, N. J. — On display will be *Mol-Iron*—clinically proved the most effective iron therapy known—available tablets and liquid. Courteous Medical Service Representatives in attendance will be happy to answer all questions and inquiries.

Booth 37—Bilhuber-Knoll Corporation, Orange, N. J.—Visit the Bilhuber-Knoll Booth for the latest information on *Valoctin,* the new sedative spasmolytic, and *Quadrinal,* the well-tolerated antiasthmatic. Your discussions of these and their original medicinal chemicals, such as *Dilaudid, Theocalcin, Metrazol, Oetin,* etc., will be welcomed.

Booth 38—Desitin Chemical Company, Providence, R. I.—*Desitin Ointment,* the pioneer in external cod liver oil therapy, combines highest potency grade Norwegian cod liver oil, Zinc Oxide, talcum, in a lanolin petrolatum base.

Desitin Ointment, excels in the treatment of traumatic injuries.

Desitin Ointment, is not liquified at body temperature, nor decomposed by secretions.

Desitin Ointment, contains no phenol or other harsh irritants, it is soothing and emollient.

Indications: Postoperative dressing, slow healing wounds, diabetic and varicose ulcers, burns, sunburn, bedsores, chafing, abrasions, and lacerations and diaper rash.

Desitin Powder: A unique medicinal toilet powder, containing crude cod liver oil, Zinc Oxide, magnesium oxide, and talcum.

Uses: As of *Desitin Ointment.*

Booth 39—Mennen Company, Newark, N. J.—The Mennen Company will exhibit *New Baby Magic-Skin Care, Mennen Baby Oil* and *Baby Powder, Mennen Castile Baby Soap* and *Baby Cream;* also, their fungicidal foot powder, *Quinsana.*

Booth 40—Ciba Pharmaceutical Products, Inc., Summit, N. J. — Ciba Pharmaceutical Products, Inc., Summit, N. J. (Booth No. 40) invite you to visit their exhibit for latest information on *Priscoline* (formerly known as Priscol), a valuable adjunct to the treatment of peripheral vascular disease. *Pyribenzamine, HCL,* the antihistaminic drug for prevention and relief of anaphylaxis and many forms of allergy will also be featured.

Representatives in attendance will gladly answer any questions about these and other Ciba products.

Booth 41—G. D. Searle & Co., Chicago, Ill.

Booth 42—South Jersey Surgical Supply Co., Red Bank, N. J.—South Jersey Surgical Supply Company of Red Bank, New Jersey, was estab-

lished twenty years ago by Mr. and Mrs. William Adam, and purchased in January 1948, by Mr. Morton Winer in the hope of expanding the services of the company more thoroughly to the hospital and medical profession.

This has been achieved and in this short time they have obtained all desirable franchises for biologicals, dressings and major and minor equipment. In the equipment lines they feature the Continental X-Ray; Burdick Direct Writing Electro-Cardiograph; the Burdick, Fisher, A.C.M.I. and Garfield Diathermies; Hanovia and Burdick Ultra-Violet Lamps; Allison furniture; Ritter Equipment, and numerous distributorships for minor equipment such as Baum, Welch-Allyn, National Electric, Birtcher, etc.

In November of 1949, they moved to new and larger quarters at 33 East Front Street, where their offices, shipping and warehousing are all under one roof in a building one block long. They now have six outside salesmen covering all of Central and Southern New Jersey from New Brunswick down to the tip of Cape May. Twenty-four hour emergency service is maintained. In their new quarters they can better than ever service the medical profession in New Jersey.

Booth 43—Winthrop-Stearns, Inc., New York, N. Y.

Booth 44—Schenley Laboratories, Inc., New York, N. Y.—Attending physicians are cordially invited to visit the Schenly Laboratories exhibit. Featured at the booth are *Rutaminal*, combining rutin, aminophylline and phenobarbital for protection in certain cardiovascular disorders and diabetic retinopathies; *Titralac*, an antacid with a titration curve like that of milk; *Pelvicins*, 200,000 unit penicillin vaginal suppositories; *Penesthettes*, penicillin lozenges with benzocaine; *Sedamyl*, the unique sedative acting without hypnosis; and *Vascutum*, a new nutritional formula for cardiovascular protection in geriatrics. Qualified personnel in attendance will provide full information.

Booth 45—The Nestle Company, Inc., New York, N. Y.—"The Nestle Company, Inc., New York, cordially invites you to visit their exhibit where specially qualified representatives will be on hand to answer your questions on any of Nestle's milk products—already best known and most used for babies 'round the world."

Booth 46—Parke, Davis & Co., Detroit, Michigan—Medical Service Members of the Parke, Davis & Company Staff will be in daily attendance at our Commercial Exhibit for consultation and discussion of the various Products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as *Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Influenza Virus Vaccine*, and others will be featured. You are most cordially invited to visit our Exhibit with the assurance that your personal interest will indeed be very much appreciated.

Booth 47 — Coca-Cola Company, Atlanta, Georgia—"Ice-cold *Coca-Cola* served through the courtesy and cooperation of *Coca-Cola* Bottling Company, Atlantic City and The *Coca-Cola* Company."

Booth 48—Hoffmann-LaRoche, Inc., Nutley, N. J.—Roche will feature three important specialties, namely, *Gantrisin*, a highly soluble sulfonamide for systemic and urinary tract infections; *Nisentil Hydrochloride*, the new obstetrical analgesic; *Thephorin Ointment*, an antihistaminic ointment especially valuable in the treatment of allergic dermatoses, pruritus and insect bites.

Physicians are invited to visit the Roche booth to discuss these and other products of interest to them.

Booth 49—Cameron Surgical Specialty Co., New York, N. Y.—The Cameron Surgical Specialty Company, as usual, has an extremely interesting exhibit this year.

Coated lenses in the long range loupes and deluxe model gastroscopes are features of exceptional value to the surgeon and diagnostician. The new Boroscope (flexible esophagoscope) is on display, also the very latest designs in electro-surgical units in six sizes.

Booth 50—Liebel-Flarsheim Company, Cincinnati, Ohio—The Liebel-Flarsheim Company cordially invites you to visit booth 50 in which their latest diathermy and Bovie electro-surgical apparatus will be available for examination and demonstration. This year's exhibit will feature the "Office Bovie" and SW-227 diathermy. Capable representatives will be on hand at all times and we hope you will stop by so that we may become acquainted.

Booth 51—Baby Service, Inc., Newark, N. J.—Baby Service, Inc., New Jersey's leading diaper service, will exhibit the features which have made it the pioneer in the diaper service field. Many of the *firsts* which have been introduced by Baby Service along with the latest scientific improvements will be displayed.

The theme of the Baby Service booth will be so completely different from the usual diaper booth and a real treat will be in store for those who stop and say hello.

Booth 52 — Whittier Laboratories, Chicago, Illinois—You are cordially invited to visit the Whittier Laboratories exhibit where our representatives will discuss *Arthralgen, Bezon, Caubren Compound, Chlorothen Whittier, Ertron, Infron, Laurium* and *Resmicon*.

Booth 53—C. V. Mosby Company, St. Louis, Mo.

Booth 54 — Upjohn Company, Kalamazoo, Michigan—The Upjohn exhibit will present the anti-coagulant family: *Heparin, Depo-Heparin*, and *Dicumarol*, with particular emphasis placed upon *Depo-Heparin*.

When heparin is prepared in a gelatin vehicle *(Depo-Heparin)* and administered intramuscularly, markedly prolonged effects are obtained. A single injection of 1 c.c. (200 mg) of *Depo-Heparin* will prolong the blood coagulation time for about twenty-four hours.

Booth 55—C. B. Fleet Co., Inc., Lynchburg, Va.—C. B. Fleet Company, Inc., cordially invites you to stop at Booth 55 to see the exhibit of *Phospho-Soda (Fleet)*. *Phospho-Soda (Fleet)* is a solution containing in each 100 c.c. sodium biphosphate 48 gm and sodium phosphate 18 gm.

Phospho-Soda (Fleet), over the years has won discriminating preference by thousands of physicians—because of its controlled action. . . . its freedom from undesirable side effect—and its ease of administration.

There is only ONE *Phospho-Soda (Fleet)*.

Booth 56—Cosmevo Surgical Supply Co., Paterson, N. J.

Booth 57—Dy-Dee Wash, Inc., Collingswood, N. J.—Dy-Dee Wash, Inc. of South Jersey and General Diaper Service of North Jersey extend a cordial invitation to visit our exhibit.

From the very beginning we have used methods of processing diapers which have been controlled by regular bacteriological examinations performed by an independent laboratory under the personal direction of a Clinical Pathologist.

We are members of The National Institute of Diaper Services which has a membership of about seventy devoted to laundering of diapers throughout the United States. This organization requires that its members maintain a high, rigid sanitary standard.

A visit to our exhibit will be found interesting and profitable.

INDEX TO ANNUAL REPORTS

	Page
Adult Disease Control	226
Anesthesiology	235
Annual Meeting	219
Cancer Control	227
Cardio-Vascular Diseases	229
Child Health	230
Conservation of Vision and Hearing	229
Contract Practice	234
Councilors	214
County Societies	243
Crippled Children	230
Emergency Education Program	210
Emergency Medical Services	213
Executive Officer	214
Finance and Budget	216
Honorary Membership	216
Hospital Relationships	235
Industrial Health and Hygiene	235
Judicial Council	213
Laboratory Medicine	237
Legislation	221
Maternal Welfare	231
Medical Care of the Indigent	237
Medical Defense and Insurance	218
Medical Education	220
Medical Examiners, State Board of	241
Medical Practice	222
Mental Hygiene	232
Military Service	213
New Jersey Health Congress	242
Nursing and Nursing Education	238
Pharmaceutical Problems	239
Physical Medicine	239
President	206
Public Health	225
Public Relations	223
Publication	217
Radiology	240
Rural Health	232
School Health	233
Scientific Exhibits	220
Scientific Program	220
Scientific Work	218
Secretary	208
State Board of Medical Examiners	241
Treasurer	207
Tropical Diseases	234
Trustees	208
Tuberculosis	233
Venereal Disease Control	234
Veterans Liaison	213
Welfare	221
Woman's Auxiliary Advisory	218
Workmen's Compensation	240

THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS TO THE HOUSE OF DELEGATES

May 22, 23 and 24, 1950

PRESIDENT

James F. Norton, M.D., Jersey City

The time has come for me, as retiring President of The Medical Society of New Jersey, to render to you, the members of this Society, an account of my stewardship of one year. It was an exciting progressive, tumultous and for me, educational, year. It was, as I predicted in my inaugural speech of April 27, 1949, an important year in the affairs of organized medicine in the U. S. A.

In my opinion, the most important accomplishment of the year was the very active campaign we waged against compulsory health insurance and for voluntary health insurance, culminating in the creation of the "New Jersey Plan". If you will bear with me briefly, I would like to quote a few sentences from my speech of a year ago. "We agree," I said, "that there is need for cohesive action concerning the National Health Program. We agree with the President of the United States that it is an important problem. And we most heartily agree with our parent organization, the A.M.A., that there should be a well-delineated, sharply defined, well-articulated, forceful national health program for these United States." I ventured to assert that, "We have the answer . . . if only we can learn to use it . . . to exploit it to its maximum. We must use it. We must effect a more widespread dissemination of all the voluntary plans."

This, gentlemen, has been our unswerving aim and purpose: to unlock the energies, to stimulate the imagination and to inspire the determination of doctors and laymen alike to solve our mutual problems through voluntary cooperative action. We have endeavored to wage a positive battle. "Accentuate the positive—Eliminate the negative" could have been our theme song. We accepted invitations to participate in debates and in forums, to lecture alone or as part of a program, no matter how small the audience or how distant the town. And always the subject was that of national health insurance. The county societies have joined the State Society in meeting and talking with the lay public; serious and constructive thought has been given by all the components of The Medical Society of New Jersey to this most pressing problem. The result of this concerted effort throughout our campaign has been the emergence of The Medical Society of New Jersey as the undisputed leader of what is generally conceded to be the most practical, definitive national health program yet to be offered in the United States.

The tremendous response to the "New Jersey Plan" convinces me beyond a shadow of a doubt that we have found, if not the answer, then at least the key to the solution of this very controversial problem of health insurance. We feel that it is a standard to which all persons right thinking may repair. The nationwide recognition given to the "New Jersey Plan" indicates most emphatically an overwhelming approval; this recognition comes from editorials by newspapers and periodicals, medical men, the lay public at large in the many forms of human communication. Such tremendous response to our efforts is vastly reassuring, but it is at the same time rather frightening because it puts a grave responsibility on our doorstep. We have but half a creature: it has a body but it has no life. We must breathe life into this yet inanimate thing called the "New Jersey Plan". That is our responsibility and it means more and harder work. Thus do I recommend to you, the members of The Medical Society of New Jersey, the dedication of all your energies, without stint or reservation, in the years immediately ahead, to the active fulfillment of the purposes and promises contained in the Plan. We have set the pace for the American medical profession; we are obliged to keep faith with ourselves, our fellow doctors and our patients.

I will not attempt to mention all the officers

and committees who have rendered important service during the past year. They have shown a real devotion to the affairs of the Society and are responsible for the successful completion of this administration.

Lest you think The Medical Society of New Jersey labored to bring forth the Plan to the exclusion of all other achievements this year, I desire now to correct your quite understandable assumption. We inaugurated new programs for the improvement in medical welfare services, for the administration of polio control, for public education regarding epilepsy and for aid to the epileptic patient; we formulated a new code for autopsy procedures; we initiated the plan for the reception of grievances and the self-discipline of the profession that is to be offered by the Judicial Council. We progressed in our work towards the control of cancer, tuberculosis and heart disease. We improved constantly in our relations with the press and radio. We furthered our efforts to improve and extend health services in schools. So we can truly say, "Gentlemen, we've had a busy year".

Just a few short weeks ago, our Society sustained a severe and serious loss in the sudden and untimely death of Dr. Norman M. Scott. Dr. Scott's contributions to the affairs of The Medical Society of New Jersey need no elaboration by me—suitable recognition has already been made by a memorializing resolution from the Board of Trustees. I here now, personally desire to make formal acknowledgment and express appreciation of Dr. Scott's active support in all matters and in particular for his great contribution in the many conferences leading up to the formulation of the "New Jersey Plan".

I have met with many of the officers and members of the Woman's Auxiliary at various times and in various localities. I wish it was possible to say to them individually how much I feel indebted to them all for the many evidences of their fine support and active participation in the various phases of our program,—but since this is impossible—I say to all of you, "I am indeed grateful".

The office staff in Trenton has been most helpful. Frankly, I feel an embarrassing inadequacy when I look for words to express my appreciation of their work.

I cannot imagine anyone in this era undertaking the duties of your presiding officer, and being denied the support in "the front office" of the very capable and unusual services of Mrs. Edith L. Madden. She has been most cooperative, most helpful, and above all most loyal—to say now a mere "thanks" is an understatement bordering on the ridiculous. But for the record, "Thank you, very much".

Finally, our Executive Officer, James E. Bryan. The nature of most of the work this year was quite different from that of yesteryear. As your President, I freely and quickly admit I had need for much more than secretarial services. I needed at times an "alter ego" and I assure you it was most comforting to find in Mr. Bryan such a tower of strength. It all added up to encouragement, aid, and support which one must have if he is to function effectively on all fronts as your President. For all of this—again many, many thanks.

Viewing the year in retrospect, I am convinced now more than I ever dreamed I would be, that without the unswerving and most faithful support accorded me by the Board of Trustees, I would have accomplished very little indeed, if anything. They have given such an impetus to the formulation and definition of new and progressive policies, and have advanced the scale of implementation of these policies to such an extent, I feel certain that for many years, surely as long as the present personnel of the Board serves, there will be no turning back. It was very enjoyable serving with them, but it was most enjoyable having their fine support.

I was forever conscious, throughout the entire year, that the rank and file of the general membership was behind our every effort; the multiple evidence of loyalty from the many component societies, I assure you did not pass unnoticed. On the contrary they contributed something of a joyous tolerance and forbearance to what otherwise might have been a well nigh insufferable burden.

TREASURER

George J. Young, M.D., Morristown

As the fiscal year does not close until May 31, 1950, the annual report cannot be submitted at this time. An interim report covering the accounts up to that time will be presented to the House of Delegates at the first session on May 23, 1950.

SECRETARY

MARCUS H. GREIFINGER, M.D., Newark

Your Secretary appreciates the honor bestowed on him in being elected to office last fall to succeed Dr. Earl LeRoy Wood who resigned because of ill health. The duties of the Secretary's office have been carried out as prescribed in the Constitution and By-Laws. One duty is the compilation of the Official List of Members. It is regrettable to note from the following statistics that 12 per cent of our 1949 members are delinquent in the payment of their 1950 dues.

Active Members, 1950 Official List		4,590
Associate Members, 1950 Official List		159
Members Deceased, March 1949 to March 1950		59
Transfers, March 1949 - March 1950		
In, from other states	1	
Out, to other states	16	
Within the state	19	
	—	36
Resignations, March 1949 - March 1950		16
New and Reinstated Members		180
Delinquent members (members in 1949, not paid at time of Official List closing)		628

Members who are delinquent in the payment of their yearly dues are automatically dropped on March 1 from the rolls of the State Society; their names are eliminated from the mailing list, they are dropped from the certified membership report to the A.M.A., and their insurance contracts are jeopardized. Your Secretary strongly urges each member to view his Society dues as an obligation to be paid by January 1 of each year. Prompt payment will insure prompt reporting for the Official List and eliminate any break in membership record and membership benefits.

In November 1949, your Secretary attended the Annual Conference of Secretaries and Editors at A.M.A. in Chicago. From observations of activities around the country as reported at the Conference, New Jersey is well advanced in its activities and programs.

BOARD OF TRUSTEES

L. SAMUEL SICA, M.D., Chairman, Trenton

Five regular and one special meeting of the Board of Trustees have been held since last April. Abstracts of the actions taken by the Board have been published in THE JOURNAL, and copies of the minutes have been transmitted to county society secretaries for reference and report at county meetings.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

The revised Medical-Surgical Plan, raising subscriber income limitations to $5000 was put into operation June 1, 1949. Approval was also given to the issuance of direct enrollment subscription contracts, to include maternity benefits of $75, covering prenatal and postnatal care.

A committee consisting of representatives of Hospital Service Plan, Medical-Surgical Plan and The Medical Society of New Jersey was formed to develop Medical-Surgical Plan publicity which the three groups can sponsor and utilize during direct enrollment of the public.

ANNUAL MEETING SECTIONS

Because of the increase in the number of section programs at the annual meeting, it was decided that the sections on medicine and surgery meet every year; that the remaining 17 sections will alternate yearly. Those not holding sessions at the Annual Meeting will be permitted, if they desire, to hold sessions at the Clinical Conference.

LISTING OF SPECIALISTS

In response to requests received from various organizations, the Board reaffirmed its action of September 29, 1946, "that the Medical Society shall at no time sponsor or publish a directory listing physicians as specialists, having specialized training or specialized interests".

GOLDEN ANNIVERSARY PRACTITIONERS

The Board of Trustees recommends to the House of Delegates that consideration be given

to honoring members who have practiced medicine for fifty years by formal resolution at the Annual Meeting.

COMMITTEE ON GENERAL PRACTICE

The Board of Trustees approved the establishment of an advisory committee on General Practice to the Subcommittee on Medical Practice.

COLORADO PLAN

At the request of the Board, the Judicial Council studied the "Colorado Plan" for receiving complaints from laymen and other sources against physicians in cases involving unprofessional conduct, violation of ethics or any other complaint of professional or public dissatisfaction. The Judicial Council has reported that inauguration of such a plan in New Jersey will necessitate revision of Chapter VII of the Constitution.

A.M.A. DUES

It is the feeling of the Board that members who pay county and state dues should be obligated to pay the A.M.A. dues. Those desiring exemption from payment of A.M.A. dues should make application direct to the American Medical Association.

CONTROL OF POLIOMYELITIS

A code of *Recommended Practices for the Control of Poliomyelitis* was published in the March Journal. It was drafted by the Public Health Committee in cooperation with representatives of the State Department of Health, New Jersey Hospital Association, the State Nurses Association, and the New Jersey State Academy of Pediatrics, to answer the needs frequently expressed by health officers, hospitals, physicians and others for an up-to-date authoritative reference and guide for meeting practically the many problems related to the control of poliomyelitis and thus prevent confusion, panic and fear. The recommendations were approved by the Board of Trustees and copies were sent to nearly 500 health officers, hospital administrators, nurses, and other interested persons and organizations.

REGULATIONS CONCERNING AUTOPSIES

The inter-related duties of the hospital administrator, the pathologist and the mortician concerning the handling of patients after death and regulations concerning autopsies were drafted in a set of recommendations by the Committee on Laboratory Medicine. This *Code* has been agreed upon by the New Jersey Society of Clinical Pathologists, the New Jersey Hospital Association, the New Jersey Society of Funeral Directors, with approval of the Trustees by The Medical Society of New Jersey. The *Code* appeared in the April Journal. Copies have been sent to the hospital administrators, pathologists and morticians throughout the state and the Advisory Committee has been instructed to act as a bureau of complaints in regard to the matter of autopsies.

NEW JERSEY PLAN

A conference group established jointly by the Board of Trustees of The Medical Society of New Jersey, the Medical-Surgical Plan of New Jersey and the Hospital Service Plan of New Jersey was requested to review the relationships between The Medical Society and the voluntary hospital and medical care plans and to develop a method for mutual cooperation so that the full influence of The Medical Society could be brought to bear in developing, improving and increasing the enrollment of the voluntary health insurance plans in New Jersey. The conference group attempted to show in its proposals how the voluntary plans could meet the needs of all classes of people without requiring us to resort to any broad national legislation or any action that might bring about governmental control of medical practice.

A draft of the statement by President Norton comprising a series of twelve proposals for a national health and medical care program which has subsequently become known nationally as the "New Jersey Plan", was unanimously endorsed by the Board of Trustees on January 15 and the President was authorized to make a public announcement of the program on January 30.

A press conference was held on January 27 in Newark, and on January 30 the statement was released to the public. It received prominent newspaper notice and unanimously favorable editorial comment in the press throughout the eastern part of the country.

This program was the subject of informal discussion at a meeting in Chicago on February 12 on the A.M.A. National Education Campaign. The reports on this meeting indicated some displeasure among some of the officers of the American Medical Association at the fact that The Medical Society of New Jersey had offered proposals of national significance. There were other evidences that the meaning and purposes of some of the specific proposals in this program were misunderstood.

At its meeting on February 19, 1950, the

Board of Trustees unanimously reaffirmed its endorsement of the New Jersey Plan as issued; authorized a letter to be addressed to the Board of Trustees of the A.M.A. commenting upon the several points of misunderstanding or difference and informing the A.M.A. Board of Trustees that President Norton had been authorized to appear before that Board to elucidate the points of difference, if the A.M.A. so desired; and advising the A.M.A. Board of Trustees that information concerning the New Jersey Plan was to be sent to all members of the A.M.A. House of Delegates in advance of the A.M.A. San Francisco session in June.

At the same time, the Board of Trustees instructed the New Jersey Delegates to the A.M.A. that the New Jersey Plan, as promulgated, be introduced by our delegates at the San Francisco meeting and that copies of the resolution to be introduced be sent prior to the San Francisco meeting to all A.M.A. delegates together with a copy of the Plan.

The proposals offered by our Society are constructive, practicable and worthy of national consideration by the profession. We are unanimously convinced that these proposals are entirely in line with the publicly announced policies of the American Medical Association and that they comprise a service to the A.M.A. in that they spell out a detailed and specific program for accomplishing the broad objectives set forth in the A.M.A.'s own national health program. It is in this sense precisely that they have been greeted by disinterested commentators in many parts of the country.

SPECIAL COMMITTEES

EMERGENCY EDUCATION PROGRAM

James F. Norton, M.D., Chairman, Jersey City

The Coordinating Committee on the Educational Program was established by the Board of Trustees in April 1949 and was given extensive authority to carry out New Jersey's responsibilities in connection with the national educational program for promotion of voluntary health insurance and in opposition to national compulsory health insurance.

This committee comprises the President, President-Elect, First and Second Vice-Presidents, the Secretary, Treasurer, Chairman of the Board of Trustees, and the Chairman of the A.M.A. Delegates. The committee reports directly to the Board of Trustees. The following is a summary of the work of this committee during the past year.

The committee met with the members of the "New Jersey Committee of 21", representing all the county societies, in a special conference during the course of the last Annual Meeting of the Society in April 1949. At this time the educational program in New Jersey was reviewed and the cooperation of the county societies was solicited in setting up the "1-10-20 Plan". The purpose of this plan, of course, is to provide a method by which every member of the Society may contribute to the success of this program and the full potential influence of the entire profession can be mobilized. While the "1-10-20 Plan" exists on paper in every county, and while many counties have made a determined effort to put the plan into full effect, much remains to be done. This plan still offers every member of the Society an opportunity to take his part in the most vital contest in which the American medical profession has ever been engaged.

ENDORSEMENT CAMPAIGN

A second major feature of our program has been the solicitation of resolutions of endorsement of our position in reference to health insurance from lay associations and public organizations of all kinds. Thus far, the office of the State Society has been informed of the adoption of such resolutions by forty-two state and local organizations throughout New Jersey.

In this connection, we should like to point out that it is far more important for a legislator to know how the Woman's Club or Legion post or Grange in his own locality feels about this problem than it is to be informed that the National Grange, the National Legion, or the National Federation of Women's Clubs has taken a stand against compulsory health insurance. We have requested, and we take

this opportunity to repeat the *recommendation* that every county society make it a major item of immediate business to obtain resolutions from every local unit of every national or state organization which has declared itself on a state or national basis on the subject of voluntary vs. compulsory health insurance.

SPEAKERS' BUREAUS

A third major element in our campaign has been the provision of speakers for lay meetings of all kinds, qualified to discuss the issue of voluntary vs. compulsory health insurance. We have enjoyed excellent cooperation from most of the county societies. We must continue to be prepared to furnish well-informed speakers on short notice to lay groups of all kinds throughout the state.

The Coordinating Committee feels that, wherever possible, we should avoid participating in debates with other members of the medical profession. In general, it is not an edifying spectacle to find two physicians disputing each other's statements. Such affairs usually result in more confusion than enlightenment and the time available for presentation in a debate, as a rule, does not permit either side fully to develop its case.

Your Coordinating Committee feels, moreover, that the phase of mere opposition to compulsory health insurance is largely a thing of the past and that our greatest opportunity to gain public support and confidence is in the exposition and promotion of voluntary health insurance and in promoting the idea that all of our medical problems can be solved by cooperative, voluntary action along the lines proposed by this Society in its twelve-point plan announced in January 1950.

For these reasons we discourage participation in pure debates but we most emphatically welcome every opportunity to set forth our constructive proposals for solution of the people's problem.

DISTRIBUTION OF LITERATURE

A fourth major element in our state campaign has been the distribution of campaign literature. The bulk of the literature distributed has, of course, come from the American Medical Association. A recent analysis of the distribution of campaign literature, published by Whitaker and Baxter, National Campaign Directors, shows that approximately 50 million pieces of literature had been distributed by the national headquarters, or approximately one piece for every three people in the United States population. The national "saturation" has, therefore, been about 33 per cent. Of the material prepared by A.M.A., 39 per cent has been distributed through the individual physicians, 33 per cent through the state medical societies, 14 per cent through the county medical societies, and the rest through other agencies. The national average shows that each physician has received 120 pieces of A.M.A. literature.

According to these yardsticks, Whitaker and Baxter give New Jersey about an average position. Their records show a saturation of 34 per cent of our total state population, with 1,470,965 pieces of A.M.A. literature being sent into this state. Of this total, 28 per cent has been distributed through the State Society, 6 per cent directly through the county medical society, 48 per cent directly through physicians, 3 per cent through dentists, 6 per cent through druggists, 4 per cent through lay groups, and 5 per cent through miscellaneous individuals. New Jersey is listed as 21st among the states in the degree of "popular saturation" with A.M.A. literature.

All this, however, fails to take into account the fact that New Jersey, unlike many other states, has distributed this literature largely on request. The State Society has not sent out unsolicited packages of material; we have distributed samples, subject to order by the physician. Furthermore, no account is taken of the distribution of literature prepared by the State Society itself. On this point, we have distributed 166,493 copies of the several publications issued under the imprimatur of The Medical Society of New Jersey.

It is hoped and recommended that, through a wider activation of the "1-10-20 Plan", all the literature in our hands will ultimately reach the lay people in whose hands the decision rests.

BULLETINS TO COUNTY SOCIETIES

At various times during the year, the Coordinating Committee has issued seven special "Communiques"; Communique No. 1 set up the procedures for the "1-10-20 Plan"; Communique No. 2 followed up this same matter; Communique No. 3 announced two new pamphlets available from A.M.A.; Communique No. 4 reported on several additional pieces of literature available in limited quantities for special purposes, requested that all Legion posts be contacted for endorsements, and made suggestions for the maintenance of the local Speakers Bureau; Communique No. 5 offered suggestions concerning inter-professional relations with pharmacists and personal visits with Congressmen, also, methods of enlisting lay speaks; Communique No. 6 made further

suggestions concerning the "1-10-20 Plan", reported on the distribution of campaign literature to date; and Communique No. 7 reviewed progress through January 1950, called attention to new radio programs available on socialized medicine, outlined the policy concerning debates, and included a statement concerning the Medical-Surgical Plan of New Jersey.

In addition to these Communiques, there have been numerous special memoranda announcements and letters sent out to the county societies and various lay groups from time to time.

We are especially indebted to the Woman's Auxiliary to the State and county societies for their active interest and help in this campaign. As a matter of fact, in some counties a considerably more effective job of organizing on the "1-10-20 Plan" has been accomplished by the Auxiliary than by the Medical Society itself.

WHERE DO WE GO FROM HERE?

At the National Conference on the Educational Campaign held in Chicago in February, Mr. Clem Whitaker remarked that "We can't last long just beating bills". His partner, Miss Baxter, assured us at this meeting that we are now "definitely off the defensive" in this campaign. Our own impression, gathered from scores of contacts with lay people of every persuasion and in every part of New Jersey, has convinced us that mere opposition to compulsory health insurance and mere lip service to the principle of voluntary insurance is not enough to carry this battle.

The time has come for us to respond boldly, courageously and explicitly to the public demand for medical leadership. The people are confronted with definite and urgent problems in their need to obtain and their desire to pay for medical service. We know what these problems are and we have long and loudly proclaimed the principle that every one of these major problems can be solved by voluntary, cooperative action.

In an effort to satisfy the demand for medical leadership, to bring about a closer working relationship between the profession and the voluntary insurance plans which were created by us, to spell out a detailed and specific program for accomplishing the objectives we have so long supported—and to demonstrate that our problems can be solved by voluntary, cooperative effort—The Medical Society of New Jersey developed its twelve proposals for a national health and medical care program which were announced to the public on January 30, 1950.

The public response to this announcement has been so tremendous and so uniformly favorable that we are convinced beyond a scintilla of doubt that we have found the formula for creating a new partnership between the people and the medical profession for the solution of our mutual problems.

Our proposals acknowledge the need of applying the principle of subsidiary aid to the solution of our problem, but we insist, and our program insures, that this aid will be subsidiary and that this program will keep the government in its proper place as the servant—not the master—of the people. This program was announced with a deep conviction that it is a sound, practical plan. This conviction has been heightened and deepened with the passing of every day since the announcement of these proposals by the hundreds of friendly statements and letters of support we have received from people in every walk of life and from nearly every state in the union.

Since we believe this program is right and since so many of our fellow citizens agree with us, we have profound moral responsibility to carry this program to realization.

Our first step, of course, is to submit it to the American Medical Association. By time this annual report is published, the preliminary steps toward submission to our national body will be well under way.

Regardless of what form this program may take when it emerges from consideration by the House of Delegates of the A.M.A., we are finally committed to it as a program of action for New Jersey. Each of the twelve proposals has been discussed in detail with various local organizations who have offered their help, expressed their interest, and requested our advice as to what steps can be taken to realize these various proposals.

Accordingly, the Coordinating Committee *recommends* that in addition to a full prosecution of the National Education Campaign against compulsory health insurance, a major activity of The Medical Society of New Jersey for 1950-51 should be the militant promotion of these proposals within the state of New Jersey in order that we may prove, regardless of what happens on the national scene, that we have the answer to the challenge of providing more and better medical care to all within our own state.

EMERGENCY MEDICAL SERVICES

Andrew F. McBride, Jr., M.D., Chairman, Paterson

In March of 1949 the semi-annual meeting of the Council on National Emergency Medical Services was attended by Dr. Gerald W. Sinnott in Chicago. A report of the activities of this committee was filed. In April, a joint meeting of this committee and the committee of the New Jersey Hospital Association was held to consider the problem of recruiting medical officers for the armed services. More particularly, this group considered those doctors who had been trained at government expense during the war and were then serving internships or residencies. A program agreeable to both organizations was worked out.

A communication was dispatched to Governor Driscoll informing him of the existence of this committee and its willingness to cooperate in any state program for the control of emergency or disaster.

In conjunction with officers of The Medical Society of New Jersey, a decision was reached *not* to send a representative to the meeting of the Council on National Emergency Medical Services to be held in Chicago on April 22, 1950.

MILITARY SERVICE

Stewart F. Alexander, M.D., Chairman, Park Ridge

No matters of concern to the Society were brought before the Military Service Committee during the current year, and the Committee has no recommendations to make at this time.

VETERANS LIAISON

Joseph F. Londrigan, M.D., Chairman, Hoboken

At the time of the writing of this report, no matters have been referred to the Special Committee on Veterans Liaison. To our knowledge, also, there are no problems in this field requiring the attention of the Committee at present.

JUDICIAL COUNCIL

Vincent P. Butler, M.D., Chairman, Jersey City

The Judicial Council has held two meetings. The purpose of these meetings was to study plans for a grievance committee in The Medical Society of New Jersey which would settle complaints arising in the profession among members and in their relation with the lay public. It is our opinion that this can be carried out through the Judicial Council and plans for such a Committee have been formulated. It is contemplated that in matters of ethics and discipline, the Judicial Council shall have referred to them and have final decision on all questions involving (a) membership in The Medical Society of New Jersey, (b) controversies arising under the Constitution and By-Laws of The Medical Society of New Jersey,

(c) matters pertaining to ethical conduct of members in relation to other members or the public. In order to define more clearly the function and authority of the Judicial Council some change must be made in the Constitution and By-Laws. These have been presented to the Committee on Constitution and By-Laws for action at the Annual Meeting.

FIRST DISTRICT

Union, Warren, Morris and Essex Counties

Francis C. Weber, M.D., Councilor, Newark

During this year nothing was brought to my attention for adjudication. There were two meetings of the Judicial Council to consider the "Colorado Plan" and certain proposed changes to the Constitution and By-Laws which were attended by me. Details of these meetings undoubtedly will be reported by the proper officer.

SECOND DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

Vincent P. Butler, M.D., Councilor, Jersey City

The report of this District is included in the general report of the Judicial Council beginning on the botton of page 213.

THIRD DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

Barclay S. Fuhrmann, M.D., Councilor, Flemington

The Councilor for the Third District reports no action during the past year. Apparently nothing has occurred which has required his attention.

FOURTH DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

D. F. Featherston, M.D., Councilor, Asbury Park

Since there was no business to be discussed before the Fourth District for the year 1949, no meetings were held.

FIFTH DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

Chester I. Ulmer, M.D., Councilor, Gibbstown

No matters of an ethical or judicial character were brought to the attention of the Councilor of this district during the year.

It would appear that the county societies in this district are functioning well and with harmony.

EXECUTIVE OFFICER

James E. Bryan, Trenton

The year now closing has been devoted primarily to the vital struggle for the freedom of medical practice and to turning back the threat of government control and dictation in medical affairs.

With the guidance of your Coordinating Committee and under the inspiring leadership of your president, much has been accomplished to awaken the people to the frauds and fallacies of compulsory sickness insurance.

To date, forty-two lay organizations in New Jersey have allied themselves with us in opposing federalized medicine and in support of voluntary prepayment for medical care. Hundreds of local organizations have invited members of our county and state Speakers Bureaus to address their members, and more than 1,700,000 pieces of educational literature have been distributed throughout the state.

For the most part, the response by the various county medical societies to the plans offered by the State Society has been most encouraging. Nearly every county medical society has organized its entire membership for action through the "1-10-20 Plan" and a far greater number of members have taken an active part in this Educational Program than have ever

participated in any other specific activity in the long history of our Society.

Unquestionably the most impressive accomplishment of The Medical Society of New Jersey during the past year — in winning friends and building popular confidence in the motivation and purpose of the profession—was the promulgation of the Society's "Proposals for a National Health and Medical Care Plan". By offering this program, The Medical Society of New Jersey demonstrated its concern for the public welfare. At the same time, it proved to the satisfaction of most of our friends, that the things they most want of medicine can be provided by cooperation and without resort to governmental intervention.

In setting forth this plan, we have shown our willingness to provide leadership and initiative in solving the people's medical care problems. They now rightly expect us to carry on and to make good on the promise of the "New Jersey Plan"—regardless of whether it may subsequently be accepted by our sister states and by the American Medical Association as a guide for action. It seems to me that we have an inescapable obligation to furnish a continuing leadership in carrying out this program—and we are assured of the utmost public support in so doing.

If I were to summarize our position at this time, I would suggest that we are in a most advantageous position to carry through this fight for the preservation of good medical care and the freedom of medical practice to a successful conclusion in New Jersey. We have an impregnable case against state medicine. We have an active, militant organization to fight the battle. We have the confidence and support of leaders of public opinion in nearly every walk of life. And, perhaps most important of all, we have now an affirmative, practical program that will meet the needs of the hour and has already met with a most encouraging response from our lay friends.

The normal public service activities and programs of the Society have been carried forward during the year. In addition, we have taken a number of outstanding forward steps. The first state-wide medical press conference last November, the development and announcement of our cooperative program for polio control, the Governor's conference on heart disease, the continued improvement in provision of medical welfare services for various categories of needy people, our state-wide progress in providing 'round the clock emergency service plans in family emergencies, the improvement and extension of coverage of the Medical-Surgical Plan—these are a few examples. In all these matters, The Medical Society of New Jersey has played an active and leading role. They testify to our leadership in community affairs and they have helped to build for us the solid confidence and support of the people.

A general conception of the variety and extent of your Executive Officer's formal contacts both inside and outside the medical profession, may be derived from the following brief statistical report of the meetings and conferences he has attended between May 1, 1949, and April 1, 1950:

Twenty meetings of county medical societies.

Thirty-seven meetings of State Society and Woman's Auxiliary committees and groups.

Nineteen meetings of other state-wide organizations.

Forty-seven conferences on special subjects with official state departments or outside state organizations.

Eleven meetings of Councils of Social Agencies and School Health Councils.

Eight formal addresses before lay groups.

Five press and radio conferences.

Five national or regional American Medical Association meetings.

Three meetings and conferences of the New Jersey Health Congress.

Eight miscellaneous conferences with important outside personages or agencies.

Two national meetings of other organizations.

One testimonial dinner.

Much of the daily work of your Executive Officer is reflected in the reports of the various committees and of the Board of Trustees.

In concluding this report, I wish to pay tribute to the efficient and devoted service of every member of our executive staff. They have all shown a lively interest and a great loyalty to the affairs of the Society. Much of the work for which I may inadvertently be personally credited could never have been accomplished without the cooperation of our staff.

Finally, may I express my deep gratitude to Dr. Norton, to the members of his administration, and to the officers and members of the county societies with whom I have had the privilege of working during the year, for many kindnesses and much encouragement.

We may all take pride in our association with The Medical Society of New Jersey and your Executive Officer considers it a high privilege to have been of some small service to you in the year that has passed.

STANDING COMMITTEES

FINANCE AND BUDGET

David B. Allman, M.D., Chairman, Atlantic City

Each year, certain sums are "earmarked" for various anticipated expenses to be incurred by the Society during the ensuing year. These include all salaries, Home expenses, publication of The Journal, committee expenses, and other items necessary for the proper functioning of our Society.

It is never possible for the Committee on Finance and Budget to present its final report in time for publication in the May Journal because the fiscal year of The Medical Society of New Jersey does not end until May 31. We cannot with certainty ascertain that far in advance how much (if any) money is left in any of the budgetary accounts, nor can we always be reasonably sure at such an early date what the anticipated expenses will be for the ensuing year.

In spite of the greatly increased tempo of the Society's activities, the various committees have responded splendidly in staying well within their budgetary allotments.

Your Committee on Finance and Budget has had several sessions and will continue to have regular meetings until a final accurate analysis of the situation can be made.

A strong sentiment of curtailment and conservatism is in the minds of all your officers and executives and it is reasonable to assume, and I have great hopes, that the assessment for the coming year will not exceed that of the present year.

The final budget will be submitted for approval at the Annual Meeting of the House of Delegates in Atlantic City in May 1950.

HONORARY MEMBERSHIP

Joseph F. Londrigan, M.D., Chairman, Hoboken

The Committee has no recommendations to offer this year for Honorary Membership in The Medical Society of New Jersey.

The following members have been nominated by their county medical societies for Emeritus Membership in The Medical Society of New Jersey and recommended for Affiliate Membership in the American Medical Association:

CAMDEN COUNTY

Joseph E. Roberts, Jr., Camden, age 72, retired because of age, member in good standing since 1905.

Paul M. Mecray, Camden, age 78, retired because of age, member in good standing since 1892.

CUMBERLAND COUNTY

Charles B. Neal, Millville, age 83, retired because of age, member in good standing since 1902.

ESSEX COUNTY

Clarence A. Birdsall, Caldwell, age 67, retired because of ill health, member in good standing since before 1929.

J. Franklin Chattin, Maplewood, age 76, retired because of ill health, member in good standing since before 1928.

Joseph L. Dias, Lake City, Fla., age 70, retired because of ill health, member in good standing since before 1929.

Levi Halsey, Montclair, age 90, retired because of ill health, member in good standing since before 1929.

J. Corwin Mabey, Montclair, age 77, retired because of ill health, member in good standing since before 1929.

Walter A. McCullough, Daytona Beach, Fla., age 58, retired because of ill health, member in good standing since before 1929.

Irving A. Meeker, Upper Montclair, age 77, retired because of age, member in good standing since before 1929.

Edwy L. Minard, Boonton, age 68, retired because of illness, member in good standing since before 1928.

Perry B. Preston, Newark, age 71, retired because of illness, member in good standing since before 1929.

Arthur H. Richardson, Montclair, age 74, retired because of illness, member in good standing since before 1929.

Earl H. Snavely, Miami, Fla., age 67, retired because of illness, member in good standing since before 1929.

Adelbert B. Twitchell, East Orange, age 81, retired because of age, member in good standing since before 1929.

Gertrude P. Ward, Bloomfield, age 75, retired because of illness, member in good standing since before 1929.

Alexander E. Wrensch, Montclair, age 74, retired because of illness, member in good standing since before 1929.

GLOUCESTER COUNTY

Oran A. Wood, Paulsboro, age 81, retired because of age, member in good standing since 1903.

HUDSON COUNTY

Harriet E. T. Dexter, Bayonne, age 75, retired because of illness, member in good standing since 1924.

John W. Harvey, Bayonne, age 66, retired because of illness, member in good standing since 1922.

David L. Russell, Jersey City, age 68, retired because of illness, member in good standing since 1921.

MONMOUTH COUNTY

Harry G. Thomas, New York City, age 81, retired because of ill health, member in good standing since 1929.

MORRIS COUNTY

Francis H. Glazebrook, Rumson, age 73, retired because of age, member in good standing since 1902.

George R. Hampton, Greystone Park, age 72, retired because of age, member in good standing since 1910.

Clifford Mills, Morristown, age 75, retired because of age and health, member in good standing since 1907.

Frederick H. Seward, Madison, age 72, retired because of illness, member in good standing since 1903.

PASSAIC COUNTY

Hagop K. Beshlian, Paterson, age 68, retired because of illness, member in good standing since 1927.

John H. Carlisle, Passaic, age 63, retired, member in good standing since 1917.

Cornelius VanderClock, Passaic, age 73, retired because of age, member in good standing since 1912.

SOMERSET COUNTY

Henry A. Craig, Somerville, age 69, retired because of illness, member in good standing since 1930.

PUBLICATION

J. Lawrence Evans, Jr., M.D., Chairman, Leonia

For the Publication Committee, the year 1949-50 was punctuated by one grievous blow: the death on July 27, 1949, of Dr. Henry C. Barkhorn. For twenty years, the masthead of The Journal had proudly borne his name, and to many of us—including your present chairman—The Journal will not quite seem the same without "Henry C. Barkhorn, M.D." on the editorial masthead. During these two decades, Dr. Barkhorn set the pattern for a good state medical journal: simple, practical, unpretentious, dedicated to bringing news of local medical interest to the profession, and to furnishing a vehicle for the scientific observations of New Jersey doctors. In a state without a medical school, the state society's Journal represents the major medium of scientific expression for the doctor.

In the calendar year 1949, it cost (in round numbers) about $30,000 to produce The Journal. Our revenue was slightly in excess of $25,000. Thus the actual net cost of The Journal was about $5000, which represents a cost per member of $1.00 . . . probably one of the best dollar's worth we receive.

Because of the sky-rocketting costs of printing, we decided to reduce the number of pages per issue. Except the "Annual Meeting" number, we had set each issue for one hundred pages during all of 1948 and during the first three months of 1949. Since then, in an effort to reduce costs, we have used a 92-page Journal. About half of the pages of each issue are devoted to advertising. With the decrease in the size of the issue, we had to determine what departments of The Journal to reduce. It was felt that the amount of space devoted to scientific articles should not be lessened. In fact, we had 274 pages of original articles in 1948, whereas during 1949, (in spite of reduced page total), we devoted 338 pages to scientific papers. We did effect considerable space-economy by publishing Trustees and Welfare Committee minutes in abstract rather than verbatim. This accounts for the fact that 183 pages allotted to "state activities" in 1948

had been reduced to 115 pages in 1949. Our Book Review section has continued to grow: we published 66 reviews in 1948 and 96 in 1949. We have established one of the largest, liveliest and most widely read book review sections of any state journal in the country. Some of the basic statistics are given below:

	1948	1949
Total number of pages	1256	1164
Pages of advertising	658	592
Pages of scientific articles	274	338
Number of scientific articles	79	91
Number of book reviews	66	96
Space given to scientific articles	21%	29%

The editorial office operates with its usual thrift. We have noticed that most medical journals of comparable circulation have a much larger staff. We get along with a part-time editor, a full-time assistant editor and no clerical staff. Our office expenses were less than $600 last year, which is about half of the administrative costs of the editorial offices of other journals in our bracket. Relations with the executive staff have been excellent and the Committee wishes to thank Mr. Bryan, Mrs. Madden, and the clerical staff of the executive offices for their cooperation.

MEDICAL DEFENSE AND INSURANCE

J. WALLACE HURFF, M.D., Chairman, Newark

Complete reports of experiments on malpractice insurance and accident and health insurance are not available from the insurance carriers at this date. The Committee will present its complete report at the first meeting of the House of Delegates on May 23.

SCIENTIFIC WORK

W. W. MAYER, M.D., Chairman, Jersey City

The Scientific Work Committee has no annual report to be published in THE JOURNAL.

WOMAN'S AUXILIARY

LLOYD A. HAMILTON, M.D., Chairman, Lambertville

The year's activities officially started with the Annual Spring Conference on May 23. Topic for this meeting, suggested by the Medical Society, was "What Health and Medical Services are Available to the Needy in New Jersey?". Several hundred people, representing many New Jersey health and civic organizations, attended this all-day program.

An all-out effort was directed toward accomplishing the first item on the Auxiliary's proposed program for 1949-1950, i. e., "Greater Employment of the Auxiliary Influence in Opposing Current Government Health Programs".

The Auxiliary set up a 1-10-20 statewide plan, comparable to that used in the Medical Society. First action taken by this group was a directing force resulting in an overwhelming number of telegrams being sent to the congressmen from citizens of New Jersey. This protesting of the passage of a bill designed to create a cabinet post of Welfare and Health was, in some measure, responsible for its defeat.

Further action includes cooperation with Whitaker and Baxter of the National Educational Campaign in a plan to communicate by letter or in person, with presidents of all New Jersey Women's organizations. Facts on the dangers of socialized medicine are being pre-

sented to these clubs in an effort to secure endorsement favoring voluntary health plans.

The Woman's Auxiliary adopted a positive attitude in taking the stand for voluntary health insurance programs as against advocates of government controlled health programs. Rather than using a negative approach in attempting to overcome this threat, concentration of efforts was directed toward educating the public (through our various public relations activities) that we are sincerely interested in their problems and questions on health.

The Committees on Legislation and Public Relations encouraged all counties to hold Health Day Programs for the lay people. Almost 75 per cent of the counties did conduct programs of this nature.

In a book prepared by the American Medical Association's Committee on Rural Health, the New Jersey Auxiliary was commended for its initiative and ability in implementing the work of the Rural Health Committee of The Medical Society of New Jersey. Offered as informative and entertaining programs at no cost are six sound films, give-away literature and a portable exhibit.

At present the Auxiliary is, in cooperation with the New Jersey Safety Council, conducting a survey of home accidents. This survey, compiled from information supplied by general practitioners in five test counties, is the first such compilation made in this state and, to our knowledge, in the country.

In conjunction with the National Educational Campaign, we have been conducting a well organized literature distribution campaign, placing doctor-speakers in key lay organizations and maintaining an effective endorsement drive among women's organizations.

ANNUAL MEETING

Harrold A. Murray, M.D., Chairman, Newark

Shortly after the 1949 convention, your committee met with a special committee of the Board of Trustees to consider the problems that confronted us last April and to evolve a solution to them if possible. One of the prime problems was caused by the increase in the number of sections. As a result of a special hotel survey it was found that enough meeting rooms would not be available to permit all the sections to present programs each year. Trustees concurred in our recommendation that the sections on Medicine and Surgery meet at every annual meeting; that the remaining sections alternate, one half holding sessions in 1950 and the other half in 1951.

It was further recommended (and concurred in by the Trustees) that sections be limited to three speakers, not more than one of whom is to be from out of state and that the section schedules be limited to two hours.

The program and time schedule of the annual meetings were presented to, and adopted by the Board of Trustees prior to final consummation of arrangements. An advance announcement of the program was published in the February Journal. At the same time hotel reservation cards for the convenience of the membership were mailed to all.

An ever increasing interest in our meetings is shown yearly by the technical exhibitors. We regret only that available space does not permit us to allot booths to all who apply. However, we are appreciative of this interest and pleased that we were able to provide 57 booth spaces this year. Revenue from these technical exhibits "pays the freight" for the entire annual meeting. The receipts are carefully budgeted to cover the cost of the scientific exhibits, the section meetings, program printing and all the other expenses incidental to a successful convention. We cannot stress too strongly to the membership the obligation we owe these technical exhibitors. All they ask in return is a few minutes of your time to show you their products. That's not asking too much. Let's show our appreciation by visiting the technical exhibits this year and talking with the representatives!

Your chairman wishes to take this opportunity to thank all the members of the Annual Meeting Committee; Dr. Francis M. Clarke, chairman of the Scientific Program Committee, and the section chairmen and secretaries; Dr. Asher Yaguda, chairman of the Scientific Exhibit Committee; and Mrs. Edith Madden, our Convention Manager, whose great work over the years has been responsible for the success of our annual meeting.

SCIENTIFIC PROGRAM

Francis M. Clarke, M.D., Chairman, New Brunswick

The Scientific Program of the 184th Annual Meeting of The Medical Society of New Jersey will be presented in ten sections. The program appears in detail elsewhere in this issue and the officers of the various sections deserve the thanks of the Society for preparing a program of such excellence in speakers, discussors and subject matter.

At the meeting in 1949, programs were presented by eighteen sections. This increase in the number of sections was undertaken as an experiment to provide a forum for a larger number of groups and specialties. However, a count of the attendance in the various section meetings, plus a consideration of the additional expense and time required to handle this large number of sections, raised the question of the wisdom of continuing with such a large number at each Annual Meeting. The Trustees, therefore, ordered that the sections on Surgery and Medicine should meet at each Annual Meeting, and that the remaining available time should be divided alternately between the remaining seventeen established sections; and that, in addition, sections which did not assemble in May be allowed the opportunity of meeting at the Fall Clinical Session if they so desired.

The Program to be presented at the 1950 Annual Meeting reflects great credit upon the officers of the sections and upon the Society at large.

SCIENTIFIC EXHIBIT

Asher Yaguda, M.D., Chairman, Newark

This year the amount of space allocated to the Committee on Scientific Exhibits was sharply curtailed due to changes in the physical setup at Haddon Hall. Because of this, it was necessary for the committee to eliminate all educational exhibits and to refuse to accept applications from out-of-state exhibitors.

In spite of the sharp curtailment of material, the exhibits this year will be outstanding as regards quality. All of the exhibitors are members of The Medical Society of New Jersey and the material exhibited is the product of New Jersey research and New Jersey planning.

Prizes in two classes will be given as usual this year. This should make the competition among Jersey exhibitors more exciting, with a better chance for obtaining the prize.

The committee expresses regrets to those institutions and agencies which have been unable to obtain space this year. We hope that some way will be found to include them in the Scientific Exhibits in succeeding years. We also regret that we were unable to accept the applications for very excellent exhibits from our out-of-state friends in New York and Pennsylvania.

MEDICAL EDUCATION

Henry B. Decker, M.D., Chairman, Camden

The Subcommittee on the need for a medical school, under the chairmanship of Dr. Stuart Z. Hawkes, has furnished helpful information to the special commission appointed by the Governor to study this project.

The Subcommittee on long term courses (Dr. Francis M. Clarke, chairman) has organized two courses, one on surgical pathology and one on gynecologic pathology, in affiliation with Rutgers University.

The Subcommittee on Intern and Resident Training, under Dr. Samuel Cosgrove, reports progress and calls attention of the Society to the fact that there will be a shortage of interns in the foreseeable future.

The Subcommittee on graduate education (Dr. Ernest F. Purcell, chairman) has set up, in association with Rutgers University, several lecture courses throughout the state. The Rutgers plan, under the chairman, will resume

operation in Cooper Hospital within the next three months. It is planned to hold a round table discussion on graduate medical education at the Annual Meeting in Atlantic City with committee members from the various county societies. One of the problems that becomes evident is that there is a saturation point for graduate medical education, both as regards the student and the teacher.

WELFARE

Vincent P. Butler, M.D., Chairman, Jersey City

The Welfare Committee held three meetings. All were well attended. Reports were submitted by the Subcommittees and Advisory Committees. This was made possible by the fact that these committees assembled in advance of the Welfare Committee session and not on the same day as heretofore. The change was most satisfactory, for it permitted ample time for the Welfare Committee to study the reports and recommendations before taking action. Many and varied were the matters brought to the Welfare Committee. Most of these activities will be enumerated in the annual reports of the Subcommittees and Advisory Committees. Some of the major considerations during this year were: state and national legislation; leadership in community health; medical welfare service; emergency call service; speakers bureau; practices for control of poliomyelitis; eye examinations in schools; temporary disability benefits; lay clinical laboratories; examination of drivers in fatal automobile accidents; the further development of medical-surgical plans as an offset to compulsory health insurance; standards for maternity and new-born services; medical care of the indigent; nursing and nursing education.

As chairman, I wish to express my appreciation for the cooperation and splendid efforts of all the members of this most important committee.

SUBCOMMITTEES

LEGISLATION

C. Byron Blaisdell, M.D., Chairman, Long Branch

Inasmuch as the Legislature is still in session as this report is written, it is necessarily incomplete. A supplementary report will be presented at the first meeting of the House of Delegates in May.

The Legislative Committee met in October 1949, to study the situation and to review the activities of the preceding summer with reference to national legislation.

At this first meeting, the committee was honored by the presence of our President, Dr. Norton, who announced that Dr. Londrigan would act voluntarily *pro tempore* as Executive Secretary to the Committee. Subsequently Dr. Londrigan was formally appointed to this post by the Board of Trustees. Other guests of the committee included Dr. Londrigan, Mr. Gerald O'Mara, counsel to the Society, and Mr. Bryan, Executive Officer.

The Committee noted with approval extensive work carried on during the summer by the chairman and Executive Officer with relation to the President's Reorganization Plan No. 1, which had been decisively defeated in the U. S. Senate in August.

At a second meeting in January, definite action was taken in opposition to the proposed legislation for creation of a chiropractic board of examiners.

Other matters considered were a bill to license and regulate clinical psychologists, a bill to license and regulate opticians, a bill to create regional health districts, a bill to extend the legal practice of chiropodists, and a

draft of a bill for control of lay clinical laboratories.

The Subcommittee also considered the current status of sale of antihistaminic preparations, and recommendations were presented on this subject to the Welfare Committee.

We also reviewed the advisability of recommending to the Legislature a bill to permit permanent injunctions to be levied against violators of the Medical Practice Act. We were later advised by counsel that adequate legislation already exists to accomplish the purpose of such a bill.

At the Subcommittee's third meeting (in February) further consideration was given to Assembly bill No. 2 on consolidated health districts. We voted to withhold approval of A-2 pending the report of the Governor's recently appointed Public Committee on Local Health Services. Your Subcommittee is not satisfied with certain details of this bill as originally introduced although the Society is firmly on record as favoring the purpose and principle of this legislation. We approved a measure to permit certification of claims under the Temporary Disability Benefits Law for patients attended by chiropodists, for injuries and disabilities of the feet. However, we opposed a bill which would permit chiropodists to perform cutting operations and other procedures. At a subsequent committee meeting the committee conferred with representatives of the chiropodists society on this matter but the original position of this committee in opposition to this bill has not been changed.

A bill proposed by the Commissioner of Health to permit levying of a fee for blood examinations under the Pre-Marital Examination Law was opposed on the ground that the law requiring pre-marital examinations is a compulsory public health measure and that the state has an obligation to provide free service for those unable or unwilling to pay for it privately. Further consideration was given the proposal to regulate clinical psychologists. We opposed passage of such a bill this year, feeling that further study must be given this proposal.

The committee has voted to favor the principle of a plan to provide income-tax exemption for expenses incurred by a physician in taking a recognized graduate course.

The Executive Secretary of the committee attended a meeting sponsored by the Essex County Medical Society before the opening of the 1950 legislative session. This meeting was attended by practically all of the Essex County delegation and was devoted to a successful and informal discussion of legislative problems.

The most urgent legislation before the committee is A-168, the chiropractor bill. At this writing, A-168 is still held in caucus. Your committee has repeatedly circulated copies of the conclusions of the special commission authorized by the 1948 Legislature to study the chiropractic problem. This commission concluded that no change should be made by the state in the present method of licensing chiropractors. On April 3, the full text of this report was circulated by your committee to all members of the Assembly.

The committee wishes to express its appreciation to its Executive Secretary, Dr. Londrigan, and also to Mr. O'Mara, counsel, who has attended all meetings and to Mr. Bryan, Executive Officer, who has assisted the committee with its work.

MEDICAL PRACTICE

Herschel S. Murphy, M.D., Chairman, Roselle

The Medical Practice Committee has continued to work to promote the interests of the public and the physicians of our state. As in former years, we feel that the general practitioner is the backbone of practice and that his rights and privileges must be protected.

Our efforts to persuade life insurance companies to increase fee for examinations has met with some success. A number of the companies have raised their fees 50 per cent and are now paying $7.50 for a regular examination.

We object strongly to physicians being expected (voluntarily or otherwise) to contribute a fee for each hospital admission to help the hospital financially. We disapprove of physicians being taxed a flat fee on any basis whatsoever to help meet such a deficit. The proper approach is for each physician, like any other citizen, to contribute voluntarily to the sup-

port of the hospital as he sees fit, without pressure from the institution.

Progress is being made in the setting up of departments of general practice in the general hospitals of New Jersey. It is desirable that good general practitioners become "attendings" in general practice and have a voice in hospital administration.

During the year our committee went on record in favor of having interns and residents write histories and do physical examinations on *all* hospital admissions including both private and ward patients. This resolution was proposed by the Committee on Hospital Relationships.

The Advisory Committee on Laboratory Medicine has completed the code of regulations concerning autopsies. They have done an excellent job.

Dr. Reading, chairman of the Advisory Committee on Crippled Children, asked the Medical Practice Committee to approve a schedule of fees for the Crippled Children Commission in making payments for the medical care of the commission's beneficiaries. We hope to have our fee schedules in order by the Annual Meeting. While the Crippled Children Commission has no funds with which to pay fees it was felt advisable to set up a standard schedule and to take prorated fees when money is available.

The Committee on the Medical Care of the Indigent has recommended that each county medical society make a study of all publicly supported medical services in each community and that each county society work diligently to persuade each community to provide medical services to relief patients by a free choice, fee-for-service plan; also to fulfill its responsibility in providing hospital and medical care for medically indigent citizens. The Annual Report of the Advisory Committee on Medical Care of the Indigent will present further recommendations for the implementation of the Society's official policy concerning medical welfare services. The subcommittee heartily commends these proposals to the county societies.

All of the Advisory Committees have done a good job and I refer you to their respective reports for the full story of their activities.

PUBLIC RELATIONS

Luke A. Mulligan, M.D., Chairman, Leonia

The Subcommittee on Public Relations has continued to supervise and develop the normal public relations activities of The Medical Society of New Jersey during the past year. The emergency educational program (directly related to the national educational effort in opposition to compulsory health insurance) has been carried forward by a coordinating committee established by the Board of Trustees and is not a direct responsibility of your Subcommittee on Public Relations.

At our first meeting in September 1949, we made a careful study of the principal public relations activities of the Society and decided to continue the distribution of the weekly *Health Hints* service to newspapers and industrial house organs, the scheduling of A.M.A. radio programs on local stations, and the production and distribution of the monthly *Membership News Letter* as well as the quarterly *News-Letter* to lay agencies.

A special study was made of the *Junior Health Hints* service which was inaugurated in 1948. The subcommittee has received many unsolicited letters from teachers, school nurses, physicians, and others expressing appreciation of *Junior Health Hints* and requesting that they be continued. After careful deliberation, it was decided to continue this service as a monthly release rather than a weekly publication. In its revised form, it was reviewed in detail and unanimously approved. This service is sent to approximately 1700 people in the schools who have requested it.

RADIO PROGRAMS

We have reviewed and considered radio transcription programs prepared by various organizations. We find the A.M.A. transcribed health programs the best productions of this sort available.

The American Medical Association has announced this year that it has discontinued its national network program and is concentrating all of its resources on improvement and exploitation of the transcribed programs. Several of the older series of transcriptions have been withdrawn and others have been brought up to date. A half dozen or more new series have been produced within the past year.

The Subcommittee recently prepared a new plan for promotion of these programs by radio stations throughout the state and has requested the cooperation of county societies in interesting these stations in using the programs. Many station managers have informed us that this is the best transcribed "public service" material available to them. It should not, therefore, be difficult to arrange for scheduling of A.M.A. transcriptions regularly over every local radio station in New Jersey with credit to be given jointly to the county society, the State Society and the American Medical Association.

PRESS CONFERENCES

New Jersey's first statewide medical press conference was held in Trenton, November 19, 1949. Purpose of this conference was to bring about a better reciprocal understanding, as well as a more friendly mutual acquaintance between representatives of the press and of the profession. Extensive preparation was needed to assure the success of the occasion. Personal invitations were sent to the editor or publisher of each newspaper throughout the state and (through the cooperation of the county medical societies) arrangements were made, wherever possible, to have a local physician in each community accompany local editors to the press conference as his personal host.

The conference assembled at 2 p. m. and, for three solid hours, representatives of some 40 newspapers and press services fired questions and comments at a group of "experts" serving under the chairmanship of Dr. James F. Norton, our President. The American Medical Association was represented on the panel by Dr. Francis F. Borzell, of Philadelphia, Speaker of the A.M.A. House of Delegates, and by Mr. John L. Bach, A.M.A. Press Relations Director. Dr. David B. Allman represented the State Board of Medical Examiners as its president and Miss E. Elizabeth Brown, president of the New Jersey State Nurses Association, represented her group. Others on the panel were Mr. John J. Debus, secretary of the New Jersey Pharmaceutical Association; Mr. J. Harold Johnston, executive director of the New Jersey Hospital Association; Dr. Daniel Bergsma, State Commissioner of Health; Dr. Ralph Brancale, representing the Commissioner of Institutions and Agencies; Dr. Royal A. Schaaf, president of the Medical-Surgical Plan of New Jersey; and two representatives of the State Society: Dr. Luke A. Mulligan, chairman of the Subcommittee on Public Relations, and Mr. James E. Bryan, our Executive Officer.

The questions covered the widest variety of topics and, on the insistence of our moderator, Dr. Norton, no question was abandoned until the questioner expressed satisfaction with the answer.

A brief social hour was held in the late afternoon, followed by a dinner, after which a program of sports entertainment was presented through the courtesy of Hearst Publications.

At its January meeting, the Committee reviewed all aspects of this first statewide press conference and we unanimously concluded that the plan should be repeated annually. The statewide press conference produced valuable results in better press relations and we are assured by many of those who attended the first conference that a repetition of this unprecedented event would bring out several times the number who attended the first session.

Your Committee also feels that each county society should hold a similar press conference with the "fourth estate" in its own county.

MISCELLANEOUS ACTIVITIES

During the year, the Subcommittee arranged for a distribution to each member of the Society of a copy of *The Policies and Programs of Public Service of The Medical Society of New Jersey*. It is important for all members to be periodically acquainted with the State Society's principal policies and programs, and a frequent re-reading of this brochure is recommended.

The Committee has also acquainted itself with the facilities and services of the Princeton Research Service which operates the "New Jersey Poll". We believe that a continuing study should be made of the possible usefulness of this organization in helping us to analyze public opinion in New Jersey concerning the medical profession, to diagnose our public relations failures and shortcomings and, thus, to help prescribe the public relations remedies.

We initiated action during the year to clarify our policy concerning display listings in telephone directories for emergency medical call service plans or other public service projects sponsored by medical societies. The telephone company has been informed that such projects may properly be accepted for paid advertising when requested by a medical society.

The Committee also took cognizance during the year of the projects now under way in many state societies to improve the machinery for selfdiscipline of the medical profession and to provide a mechanism for satisfactory handling of complaints against members of our profession.

This matter obviously has important public relations aspects and we are encouraged to know that the Judicial Council of the Society has taken steps to develop a satisfactory plan for New Jersey.

RELATIONS WITH WOMAN'S AUXILIARY

The Subcommittee on Public Relations has approved plans of the Woman's Auxiliary for a public meeting to be held in June at which time a program will be presented to stimulate further activity and interest in the Four Point School Health Improvement Program of The Medical Society of New Jersey.

The Committee has also endorsed the action of the Woman's Auxiliary in developing a rural health education program. We congratulate the Auxiliary on its constructive work in these and many other fields. We are also grateful to the Auxiliary for the assistance given us by many of their members in promoting use of the A.M.A. radio programs and in helping us with other public relations activities.

RECOMMENDATIONS

The Public Relations Committee recommends:

(1) That The Medical Society of New Jersey sponsor another statewide medical press conference in the fall of 1950.

(2) That each county society sponsor and actively support a year-round Speakers Bureau service to provide speakers for lay groups interested in talks on health topics. It is necessary for the medical profession to exert active leadership in public health and to cooperate with all agencies interested in health education by providing such speakers.

(3) That the basic, normal public relations services of the Society be continued through 1950, including the *Membership News Letter* and the quarterly *News Letter* to cooperating agencies, the weekly *Health Hints* service, the *Junior Health Hints* service to schools, and the presentation of A.M.A. radio transcriptions through local radio stations.

(4) That The Medical Society of New Jersey urge each of its component county medical societies to concentrate during the year 1950-51 on an organized public relations and public service program, including the following features:

(a) An Emergency call service system in every community to assure adequate and prompt medical service in medical emergencies.

(b) Universal application within each county of the policies of medical welfare service already endorsed by The Medical Society of New Jersey.

(c) The organization or reorganization of county society machinery for handling grievances or complaints against individual members of the profession in accordance with a program to be presented by the Judicial Council.

(d) Leadership in community health affairs through organization of county and local health councils.

(e) Better public recognition of the services of the medical profession through the provision of a reference service for newspapers so that medical news may be properly channeled and authenticated; the holding in each county of a medical press conference between the medical society and local editors; the servicing of local radio stations with A.M.A. transcriptions and, wherever possible, with live programs for health education.

Your Committee feels that each of the above five projects should be made the subject of a special memorandum to each county society.

The members of the Subcommittee on Public Relations are to be commended for their diligence and their splendid effort which involved sacrifice in attending the many meetings which the Committee held at Trenton, during the past year. To Doctors Forte, Trewhella and Sommer and Mr. James Bryan, the Executive Officer, I extend my sincere thanks for their splendid cooperation.

PUBLIC HEALTH

SAMUEL BLAUGRUND, M.D., Chairman, Trenton

The Subcommittee on Public Health during the past four years has operated on the thesis that everything pertaining to the public health of our citizens is the direct responsibility of the medical profession. This perspective has led to concrete constructive programs. At the request of the Public Health Committee of The Medical Society of New Jersey, a joint committee of the State Department of Health, the New Jersey Hospital Association, the New Jersey Nurses Association, the New Jersey State Academy of Pediatrics, and the Public Health Committee of The Medical Society of New Jersey, formulated standards for the control of an outbreak of poliomyelitis. This material was prepared to answer the needs (frequently expressed by health officers, hospitals, physicians and others) for an up-to-date au-

thoritative reference and guide for meeting practically the many problems related to the control of poliomyelitis, and thus to prevent confusion, panic and fear.

"Public Health Week", held in 1947, 1948, and omitted in 1949, will be revived in the fall of 1950. "Public Health Week" is a means whereby authentic information can be presented to the citizens from reliable sources. It alerts the State Medical Society, the county medical society, and the individual physician as to his own responsibility to the health of the community at large.

During the past two years, in cooperation with the State Department of Education, and spearheaded by the Woman's Auxiliary to The Medical Society of New Jersey, the four-point school health program (which has received national recognition) was implemented in many counties throughout New Jersey. Again it is my pleasure to compliment the Woman's Auxiliary for their untiring efforts and enthusiasm in bringing this school health program into successful operation.

Standards for the newborn nursery and the premature baby were presented to the hospitals throughout New Jersey, and we hope that our hospitals wil conform to these minimum standards.

I take pride and express deep appreciation to my Advisory Committee chairmen and their members, for the numerous advances and accomplishments in the field of public health in New Jersey during the year.

We recommend for the second successive year that the Welfare Committee and Trustees study the problem of obtaining the cooperation of the component medical societies in carrying out the recommendations of the Subcommittee on Public Health.

PUBLIC HEALTH ADVISORY COMMITTEES

ADULT DISEASE CONTROL

Carlyle Morris, M.D., Chairman, Metuchen

The committee has continued the study to determine any physical disability that might exist in automobile drivers involved in fatal automobile accidents during the year. This project included analysis of any physical defects known to the family physician at the time the driver was involved in the accident. To date a total of 237 letters have been written and 111 replies have been received; 47 per cent. This ratio of replies is above the average of an inquiry of this type.

The committee is unable to make any deductions from this study as all drivers were declared to be in excellent physical condition at the time they were last examined by their physicians. There was one case of chronic alcoholism; one driver had suffered a coronary thrombosis in the past and one driver was known to be "very tense".

In view of the negative result of the study, the committee is prepared to make certain recommendations to the Commissioner of Motor Vehicles of the State of New Jersey. It is hoped that out of the information compiled as a result of procedures in the recommendations, data will be collected that will furnish the basis for determining the standard of physical fitness required for driving an automobile. It is believed that a physical examination of applicants for a driver's license under the conditions outlined in the recommendations will also have an effect in the prevention of fatal accidents.

Recommendations to the Commissioner of Motor Vehicles, State of New Jersey:

(1) That any automobile driver who is involved in a fatal accident be required to undergo a physical examination as soon as practical following the accident.

(2) That all applicants for a driver's license, sixty years of age or over, undergo an initial physical examination at the time of making application

and every ten years thereafter. A medical opinion as to physical fitness of the applicant to drive an automobile would be recorded.

(3) That if, in the opinion of the Commissioner of Motor Vehicles, an applicant for a driver's license presents any physical or mental defect the applicant be required to undergo a physical examination before a license is granted.

At the direction of the Subcommittee on Public Health the following recommendation is made in addition to the above:

It is realized that a study of this kind would entail the maintenance of voluminous record files, adequate secretarial staff, assistance from competent statisticians, and probably the employment of one or more full time physicians to interpret and sort the records. The Committee on Adult Disease Control is in no position to assume this responsibility. We assure the Commissioner of Motor Vehicles of every possible cooperation from our committee but feel that it is a responsibility of his department to make available the personnel required in such an extensive study.

The Welfare Committee concurred in this report on March 19, 1950, and it is now referred to the House of Delegates for approval.

CANCER CONTROL

William O. Wuester, M.D., Chairman, Hillside

Expansion of clinical facilities and activities along with an ever-increasing number of private physicians who are willing to conduct health maintenance examinations in their own offices, has brought about a striking progress in the Cancer Control Program of the New Jersey Division during the past fiscal year.

The expansion of clinics since the incorporation of the New Jersey Division of the American Cancer Society has been remarkable. Where a few years ago there were eleven clinics in operation in the state, there are today 51. Of these, 40 are participating in Part IV of the Cancer Control Program which was adopted last year as the fourth step of the program in this state. This part of the program visualizes a more equitable distribution of cancer society funds for work actually done in the diagnosis, care and follow-up of cancer clinic patients. Hospitals participating in the program are given a basic allowance of $520. per year and in addition are paid on an economical fee basis for diagnostic procedures performed for indigent and medically indigent patients. A list of the hospitals now participating in Part IV follows:

All Soul's Hospital, Morristown
Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Beth Israel Hospital, Newark
Bridgeton Hospital, Bridgeton
Burlington County Hospital, Burlington
Christ Hospital, Jersey City
Cooper Hospital, Camden
East Orange General Hospital, East Orange
Englewood Hospital, Englewood
Fitkin Memorial Hospital, Neptune
Green Clinic (Elizabeth General Hospital), Elizabeth
Hackensack Hospital, Hackensack
Holy Name Hospital, Teaneck
Irvington General Hospital, Irvington
Lutheran Memorial Hospital, Newark
McKinley Hospital, Trenton
Mercer Hospital, Trenton
Millville Hospital, Millville
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Muhlenberg Memorial Hospital, Plainfield
Newton Memorial Hospital, Newton
North Hudson Hospital, Weehawken
Orange Memorial Hospital, Orange
Overlook Hospital, Summit
Perth Amboy General Hospital, Perth Amboy
Presbyterian Hospital, Newark
Princeton Hospital, Princeton
Public Health Center, Hammonton
Shore Memorial Hospital, Somers Point
Somerset Hospital, Somerville
South Amboy Memorial Hospital, South Amboy
St. Barnabas Hospital, Newark
St. Elizabeth Hospital, Elizabeth
St. Francis Hospital, Trenton
St. Mary's Hospital, Hoboken
St. Michael's Hospital, Newark
Warren Hospital, Phillipsburg
West Jersey Hospital, Camden

During the year, the American College of Surgeons inspected a number of hospital clinics in the state. Twenty-five were fully approved and 10 were provisionally approved making a total of 35 of the 51 clinics now in operation. The remainder of the clinics have not yet been inspected.

The New Jersey Division (with the approval of the Board of Trustees, Medical Society of New Jersey and the Advisory Committee on

Cancer Control) during the past year entered into a new phase of program activity. With the formative stages of the program completed, it became necessary to provide a stimulation and encouragement both from the financial and inspirational angles to the large number of clinics that have been established since the organization of the New Jersey Division.

The southern part of the state has not been adequately covered by cancer clinics but this problem will, within a few months, be solved. New hospitals are being built in Cape May and Salem Counties and arrangements are being made to assist the clinics of these hospitals with cancer society funds.

During the year, the number of physicians who have expressed willingness to conduct health maintenance examinations by appointment in their own offices has increased. Over 200 additional doctors have volunteered to participate in this cancer detection program making the total now on the list of the society at over 1800. The private practitioner can do more to detect cancer and to aid patients in discovering cancer early than all the hospital clinics combined. This viewpoint has been adopted by The Medical Society of New Jersey and the American Cancer Society, New Jersey Division from the inception of the Cancer Control Program. Experience in this state each year has proved that the ideal set by physicians and the laymen in New Jersey is a model for other states. In many other states, the family doctor is now becoming the keystone of the cancer detection system, as he has been in New Jersey for years.

The professional and lay education programs as approved by the committee have expanded to a considerable degree during the past year. While there is still much to be done, it is felt that in only rare instances has an area been left untouched by the impact of the cancer education program. Other state-wide organizations have cooperated fully in promoting this program and great appreciation is due to all of them.

The Medical Committee has met monthly throughout the year and at several meetings has seriously discussed and considered the problem of terminal care. It has been realized from the outset that the society could not be expected to provide any great amount of funds for the care of the terminal patients. However, it was determined by the committee that some type of home nursing care and housekeeping service could be provided to a limited degree. For that reason, Part V of the Cancer Control Program was developed by the committee and has been approved by the Board of Trustees of the New Jersey Division and by the Board of Trustees of The Medical Society of New Jersey. This plan makes it possible for county chapters to expend a limited portion of their funds to provide additional care for terminal patients. This will not provide a solution to the cancer problem itself and the society and the medical profession must at all times guard against heavy expenditures which might drain the program of research, service and education which is so vital to the solution of the cancer problem.

During the past four years, The American Cancer Society, New Jersey Division has allocated to the national research program $707,092. and to the national educational program $424,555. A total of $543,432. has been expended for clinic equipment in the New Jersey hospitals and $78,023. for radium and radon seed. The society has expended $89,065. for visiting nurse services for indigent cancer patients and $40,439. for medications for these patients. In addition, $74,620. for nursing and clinical expenses of the diagnostic procedures in the clinics. The county and state educational programs have expended $98,207. in the same period of time.

The cooperation between the medical profession and the laymen active in the cancer society has been outstanding and has been commented upon at national level.

The cooperation of the women volunteers of the cancer society with the program has increased and has been outstanding during the past year. More than 10,000 women volunteers have been engaged in the making of dressings which are furnished free on request to patients, hospitals, doctors and clinics. In many of the counties, volunteer drivers transport patients to and from their homes to clinics or physicians' offices. This part of the program makes it possible for the accomplishment of many of the medical phases of the program.

The Medical Committee expresses appreciation to the laymen of the society who have given their fullest cooperation with the medical program throughout the year. Without their assistance and the funds that they have raised, the program could not have made the progress that it has made during the past four years.

CARDIO-VASCULAR DISEASES

Jerome G. Kaufman, M.D., Chairman, Newark

The chairman of the Committee on Cardiovascular Diseases reports that his committee met and discussed the problems of cardiac patients. It was decided to re-survey the cardiac clinics throughout the state to determine the number of approved and non-approved clinics. This survey is almost completed and will be reported at a later date.

The standards and minimum requirements for cardiovascular clinics have been recommended and all cardiac clinics in the state will be evaluated during the coming year.

The committee will cooperate with other interested groups to improve school health examinations, particularly with respect to heart studies. It was decided also to extend mechanisms wherever possible to aid indigent children suffering from heart disease. This is to be carried out on a county basis.

The committee favors an annual heart institute for physicians as part of an educational program. The institute would be held in different part of the state each year.

It was also thought advisable to conduct an investigation of the problem of the cardiac worker in industry and to review the legislation relating to this problem.

The committee guided the New Jersey Heart Association in planning the first Governor's Conference on Heart Disease, which was held in Trenton in the fall. A scientific session of The New Jersey Heart Association was held in Newark and was attended by about six hundred physicians. The meeting and its attendance was encouraging. The chairman of the committee reports with enthusiasm the recent opening of the St. Michael's Hospital Surgical unit for the correction of congenital cardiac deformities.

It is the aim of the committee to continue as an advisory committee to The New Jersey Heart Association and through that organization to bring the following to the profession and lay public:

(a) A well planned educational program focusing on the advances in cardiology, and also on the preventive phase.
(b) To encourage research wherever possible.
(c) To aid and assist in the establishment of community projects to provide the best possible cardiovascular medical care.

CONSERVATION OF VISION AND HEARING

Elbert S. Sherman, M.D., Chairman, Newark

Because of a number of inquiries from various sources concerning the best and most practical method of testing the vision of school children's eyes, the Committee held a meeting in Trenton for the purpose of considering this question. A resolution was passed at that time which embodied the following statements:

1. An adequate vision test should be a part of every school physical examination.
2. The use of the Snellen chart for distant vision, and its equivalent for near vision, properly utilized and supervised, is adequate for testing vision in school children.
3. This should be supplemented by the inspection and observation of the eyes by the school physician.
4. Complicated devices sometimes used in these examinations are deemed to be unnecessary.
5. Every school system should advocate the preschool eye examination of children.

The recommendations of the Advisory Committee on Conservation of Vision and Hearing, submitted through the Public Health and Welfare Committees, were approved by the Trustees and have been referred to the State Department of Education for consideration.

The Committee on Conservation of Vision and Hearing also made the following recommendation:

The Committee feels that wherever local problems arise in the school systems, the county medical society should appoint a committee on conservation of vision and have the members of that committee available to the public schools of the county for consultative purposes in arranging and carring out a proper school program for eye testing.

CHILD HEALTH

F. W. Lathrop, M.D., Chairman, Plainfield

The Child Health Committee suffered a grievous loss this year in the untimely death of Dr. Stanley H. Nichols. For many years Dr. Nichols had been the leader of pediatric thought in New Jersey. With his tireless energy and unselfish devotion to the highest ideals of medical practice, he rendered invaluable service to the medical profession by promoting an atmosphere of cooperation with other agencies working toward a common goal.

Recommendations: In the coming year, some plan for postgraduate pediatric education for the general practitioner should be developed. Our present thought is to establish traveling diagnostic clinics which would work out diagnostic problems with the local practitioners, and advise them as to treatment; but to leave actual treatment entirely in the hands of the family doctor.

CRIPPLED CHILDREN

H. Eugene Reading, M.D., Chairman, Paterson

The cerebral palsy program in this state progressed favorably during the year 1949 through 1950. There is harmonious functioning of the state cerebral palsy clinics. In the past the New Jersey Chapter of the National Society for Crippled Children and Adults, through the Crippled Children Commission of New Jersey, have furnished the monies necessary to employ speech therapists, occupational therapists and physical therapists in some of these cerebral palsy units. It is hoped that the service of these specially trained technicians will continue to be available for the coming fiscal year.

The three Elks lodges in Passaic County have shown initiative and enthusiasm in obtaining funds through a drive in the spring of 1949 to construct a building for the treatment and grade school education of cerebral palsy children. The school room in Paterson now serving as one of the Cerebral Palsy Clinic units is too small to accommodate the present number of patients. Excavation for this new building will soon be started on a site in Clifton. Committees of the three Elks lodges are working closely with your chairman, as medical advisor. Dr. Sidney Keats, who represents the Crippled Children Commission in the state Cerebral Palsy clinics, has been kind enough to attend some of these meetings of the Elks Building Committee and offer worthwhile suggestions.

The Bergen County Cerebral Palsy Center plans to build a cerebral palsy treatment unit adjoining the proposed Valley Hospital in Ridgewood. Dr. George G. Deaver will continue directing the Bergen County Cerebral Palsy Center. Dr. Deaver is director of the cerebral palsy treatment clinic of the Lenox Hill Hospital in New York and is on the faculty of New York University Medical School and at Bellevue Hospital in the Department of Physical Medicine and Rehabilitation. The Bergen County Center is stressing the treatment of the pre-school child with cerebral palsy. This new center is expected to be ready for occupancy by the end of 1950.

Better facilities are now available in New Jersey for the treatment of acute poliomyelitis patients. Since there are so few modern isolation hospitals in this state to care for the early phase of the disease, it was deemed best that general hospitals in New Jersey give serious consideration to establishing isolation facilities for the admission and treatment of acute poliomyelitis patients. Practically all of the medical and surgical specialties are readily available in our general hospitals thereby offering excellent care to these poliomyelitis patients during the first weeks of their illness. The medical and lay boards of most of the general hospitals in New Jersey have been informed of the importance of the general hospitals making the necessary isolation facilities available. Dr. Van Riper, Medical Director of the National Foundation for Infantile Paralysis was good enough to come to Paterson in June 1949 to talk to representatives of the hospitals in Passaic County on how a general hospital could play an important role in the treatment of the acute poliomyelitis patient.

Much credit is due Dr. Samuel Blaugrund,

chairman of the Subcommittee on Public Health and his Advisory Committee chairmen for formulating the *Recommended Practices for the Control of Poliomyelitis.*

Since last June an appreciable number of general hospitals in New Jersey have already provided isolation wards, or agreed to prepare such wards as the need may arise, for the admission of acute poliomyelitis patients.

Your Committee has long been interested in the schooling of the crippled child confined to a hospital. Unfortunately only a few communities in New Jersey have been able to provide teachers for these hospitalized children. At least two cities in New Jersey now lend radio receiving units to the homes of crippled children so that they can hear the proceedings of the school class along specially assigned wire facilities.

RECOMMENDATIONS

1. Improved methods for the reporting of unlisted cerebral palsy patients to the Crippled Children Commission of New Jersey and the State Department of Health.

2. Additional technicians are needed, with special training in cerebral palsy, such as physical therapists, occupational therapists and speech therapists, for the state Cerebral clinics. Unfortunately, very limited funds are now available to employ such technicians.

3. More of the general hospitals in New Jersey should be encouraged to provide isolation wards or rooms for the treatment of the acute phase of poliomyelitis.

MATERNAL WELFARE

Samuel A. Cosgrove, M.D., Chairman, Jersey City

Members of the New Jersey Maternal Welfare Committee have obtained great satisfaction from New Jersey statistics for the past year. The maternal death rate of .08 per thousand has ranked the state among the lowest in the country. It is a tremendous achievement compared to the state level of 6.1 per thousand in 1920, the year of the inception of the Committee, under the leadership of the late Dr. Arthur Bingham.

Have we reached the irreducible minimum? The answer is no. Perusal of reports coming in from over the state reveals that reduction in all classifications of maternal deaths has occurred, but particularly so in those classed as infectious. This is to be expected in the light of the dramatic effects of the sulfonamides and the antibiotic agents. However, there are many tragedies under the classifications of "toxemic" and "hemorrhagic" deaths that might have been prevented through closer supervision and greater vigilance. Towards this end, the Committee is directing its efforts.

Three steps were taken in this direction in an effort to reach more of the medical profession.

1. An open meeting under sponsorship of the Academy of Medicine of Northern New Jersey, at which members of the Committee presented cases of maternal mortalities. The presentation was in the form of a round-table discussion, at which Professor Philip Williams of the University of Pennsylvania was the guest. Discussion was invited from the floor and a most instructive evening resulted.

2. County medical societies are urged to designate one of their regular monthly meetings each year as "Maternal Welfare Night". At this time the program will be arranged by the maternal welfare committee of that county, and their maternal deaths presented. Cases are not to be identified by hospital or physician, and a general discussion is encouraged.

3. Selection of unidentified cases from the maternal deaths throughout the state each year will be made by the Committee for publication in The Journal of The Medical Society of New Jersey.

Work towards reducing infant mortality (as set up by Dr. Robert MacKenzie last year) has continued with the cooperation of the State Maternal and Child Welfare Department and the Academy of Pediatrics.

Last year this Committee, in conjunction with Dr. Julius Levy of the State Maternal Welfare Department, outlined a form of hospital standards for the ideal practice of obstetrics. This year the Committee has formulated a set of minimal requirements, based upon these standards, which is practicable to obstetrical departments of all sizes throughout the state. This has been recommended to the State Board of Institutions and Agencies. This

board is reported to be considering it most favorably.

Through unremitting investigation of each maternal death and closer supervision of the obstetrical departments throughout the state, our maternal mortality may be reduced to the level where New Jersey will lead not only the nation, but the world.

MENTAL HYGIENE

Harrison F. English, M.D., Chairman, Trenton

Three meetings were held by the committee during the current year. A great many subjects relative to mental hygiene were tentatively discussed at these meetings. The primary accomplishments for the year were as follows:

In October 1949, a survey of the general hospitals in New Jersey was undertaken by the committee to determine how many provided facilities for the care of psychiatric patients, the extent of facilities, and their plan for the establishment of psychiatric services or enlargement of existing psychiatric services. Most of the general hospitals (seventy-nine out of the eighty-one hospitals) promptly supplied the requested information and a full account of the result of this survey was published in The Journal, March 1950, p. 127.

A plan directed toward the improvement of the care of and diagnostic facilities for the epileptic was proposed and recommended by the committee and approved by the Welfare Committee. The primary object of this program is to make the public aware that the epileptic should be treated as any other individual and should not be rejected because of his disorder. The coordinator of the program, with the aid and guidance of the Council and Medical Advisory Committee set up by the plan, will seek to enlist the cooperation of the medical profession, school authorities, health officers and employment personnel in developing plans to aid the epileptic and to inform and educate the public and professional group in the community. The coordinator will cooperate with the authorities in the Department of Institutions and Agencies and with the Medical Advisory Committee in helping to promote the use of such mental treatment, clinical and educational services as may be available under the Department at Skillman Village. More will be said about this in a later report.

The Advisory Committee on Mental Hygiene has also endorsed participation by the State Society in a proposed state-wide meeting dealing with the problem of retarded children.

RURAL HEALTH

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg

This year, the Advisory Committee on Rural Health confined its activity to consultation with the Woman's Auxiliary in promotion of its rural health program.

The Auxiliary (particularly the cochairmen of the Rural Health Committee, Mrs. Bray and Mrs. Yaguda) deserve commendation for the excellent promotional job they have done. Each County auxiliary was assigned a quota of local meetings at which one or another of the following six programs were presented:

1. Health of the Pre-School Child
2. Insurance Against the Costs of Serious Illness
3. Better Public Health for Rural New Jersey
4. Prevention of Rural Accidents
5. Rural Environmental Sanitation
6. New Jersey's Plan for Providing Adequate Hospital Facilities

The county auxiliaries have already more than half met their quotas. These programs were prepared in cooperation with the New Jersey Fellows of the American Academy of Pediatrics, the Medical-Surgical Plan of New Jersey, the State Department of Health, the State Safety Council, the New Jersey Health and Sanitary Association, the State Depart-

ment of Institutions and Agencies and the New Jersey Hospital Association, for which cooperation they are recognized as co-sponsoring agencies of our rural health program. The assistance of these organizations is gratefully acknowledged.

Representatives of the State Farm Bureau and the State Grange have been helpful in placing the program before their local units, and their assistance is hereby acknowledged.

The Woman's Auxiliary is doing an admirable job in health education work and the program deserves more active support by the medical societies and participation by the members. We urge the county societies to lend better support to their auxiliary next year in their efforts to continue and expand the rural health program.

SCHOOL HEALTH

William V. Carroll, M.D., Chairman, Trenton

The Advisory Committee on School Health has not found it necessary to hold any meetings during the past year. The work of the committee in promoting the adoption of the Society's Four Point School Health Program has been carried forward through the New Jersey State Council for Improvement of School Health Services and through the various county School Health Councils which have been organized through the initiative of the Woman's Auxiliary.

Your chairman attended the meetings of the State Council and has been in frequent communication with its chairman, Dr. Grace M. Kahrs, who is also a member of your Advisory Committee. The State Council held four meetings during the year. Each session has noted considerable progress in the adoption of our Four Point Plan by local school districts throughout the state.

The Medical Society of New Jersey is greatly indebted to the state and county chapters of the Woman's Auxiliary and also to the many organizations represented on the State Council which have contributed so substantially to the promotion of our plan. We especially express our appreciation to Dr. Kahrs who, as chairman of the State Council, has skillfully and devotedly officiated at its meetings and stimulated its progress.

Almost every local school district in New Jersey has been, to some degree, affected by the impact of this Four Point Plan. Many areas have adopted it in its entirety; others have put portions of the plan into effect and in many other places the plan is receiving active consideration.

Among the activities of the State Council during the past year has been the conduct of a survey, county by county, of present school health practices and plans for acceptance of the Four Point Plan. This has had a valuable educational effect in many areas.

The New Jersey Tuberculosis League has taken an active part in helping to promote the plan, especially point 4 which recommends annual examination by x-ray of all teachers and adult school personnel in order to find early cases of tuberculosis. We appreciate the interest and assistance of the League.

Through the joint efforts of the State Council and the State Woman's Auxiliary, a complete one-day conference on the promotion of the Four Point School Health Plan will be held in June. This meeting should help in promoting public interest in this plan throughout the state and in building the cooperation of all interested agencies without which the ultimate success of our plan would be impossible.

TUBERCULOSIS

Abraham E. Jaffin, M.D., Chairman, Jersey City

During the current year, there were no matters before our Committee which necessitated any meetings. However, within the last few days a matter has been referred to our Committee. This will be given consideration between now and the Annual Meeting and a report will be presented to the House of Delegates.

TROPICAL DISEASES

Christian P. Segard, M.D., Chairman, Leonia

This Committee was originally appointed during World War II because large numbers of people in government service were exposed to tropical diseases. Another factor was air transportation for the services and civilian travel and exposure.

The Army and Naval Medical Services have set up preventive and therapeutic measures that completely screen all cases from coming in contact with civilian medical practice. The possibility of air and water transportation as carrier of tropical disease has been reduced to a minimum. This is due to very close scrutiny by the medical services at port and air fields at points of embarkation and entry.

In view of this, your Tropical Disease Committee can do little more than report extracts from the current medical literature regarding diseases considered to be almost wholly tropical.

No recommendations are offered. Thanks of the Committee are due to Mrs. Madden, Executive Assistant and to Dr. Davidson, Editor of The Journal for their cooperation with the Committee.

VENEREAL DISEASE CONTROL

Robert L. McKiernan, M.D., Chairman, New Brunswick

At the request of the Committee and the members of the Venereal Disease Control Section, the Board of Trustees authorized the changing of the name of the section to the Section on Urology. It is now felt that perhaps a more inclusive title would be Section on Genito-Urinary Diseases.

No matters were referred to the Committee during the year for consideration and the Committee has held no formal meetings.

Since the section will be privileged to present a program only at every second Annual Meeting, the Advisory Committee plans to hold a state-wide conference next fall or winter on pertinent medical subjects.

MEDICAL PRACTICE ADVISORY COMMITTEES

CONTRACT PRACTICE

Andrew C. Ruoff, M.D., Chairman, Union City

Once again it is time to report on the workings of the Contract Practice Committee.

As so often mentioned in previous reports, my Committee only functions when matters related to contract practice present themselves. With the advent of the subject of so-called socialized medicine, doctors as a whole are becoming more cognizant of their respective relationships, between them, as a class, and their patients. This, in turn, causes the profession to become economic minded. The end result has been that the Committee on Contract Practice has had no problems presented to it, which in itself indicates a healthy state, so far as our Society is concerned. It is evident that the public, as well as the different municipal authorities, are contented with the manner in which our profession is con-

ducting itself, since no grievances of any kind have arisen.

As chairman of my Committee, I have attended most of the meetings of the Medical Practice Committee, and have participated in the deliberations of that committee. It has been a privilege to be associated with so fine a body of conscientious men. Their endeavors, as I have gleaned them, indicate a wholehearted attempt in the direction of betterment for the welfare of the entire membership of our Society.

ANESTHESIOLOGY

Leo J. Fitzpatrick, M.D., Chairman, West Englewood

The Advisory Committee on Anesthesiology does not have a report at this time. No recommendations have been suggested.

HOSPITAL RELATIONSHIPS

J. Lawrence Evans, M.D., Chairman, Woodcliff

Your Chairman is a member of the Council of Professional Relationships of the New Jersey Hospital Association; is also a member of other committees which deal with nurses and hospital problems, and through these contacts is able to carry on much of the work of the committee.

For the past two years I have been attending meetings of the Advisory Committee to the State Department of Education on the question of training for practical nurses. This program has not accomplished very much to date, but it is hoped that owing to the very great need of both practical and graduate nurses that they will be able to train a sufficient number of practical nurses to alleviate the shortage.

I am also on the Committee that has to do with proposals of the New Jersey Nursing Association, which have culminated in an agreement satisfactory to hospital administrators, and also a member of a special Committee which has to do with the question of reimbursable cost to be paid the hospitals from municipalities for giving service to welfare cases.

I feel on the whole that our hospital relationships have been adequately taken care of during the year.

INDUSTRIAL HEALTH AND HYGIENE

J. Mallory Carlisle, M.D., Chairman, Westfield

The chairman of your Industrial Health and Hygiene Committee recently attended the Congress on Industrial Health in New York sponsored by the Council on Industrial Health of the American Medical Association and the Medical Society of the State of New York, and submits the following resume of the report which developed during the Proceedings of this Congress. At least in part, it is believed that the program as outlined might be applied to the industrial health problems of New Jersey:

A. Objectives.

(a) Creation of public interest and demand.

(b) Clarification of industrial health objectives and their integration into the pattern of community health service.

(c) Improvement of professional training and standards.

(d) Betterment of medical organization for industrial health on the part of individual physicians and medical societies.

B. Program.

1. The endorsement by medical societies of the principles of occupational medicine and industrial health in the undergraduate teaching program of medical schools.
2. The expansion of the practice of occupational medicine and surgery and the continued development of industrial health and hygiene.
3. Organization of sound and properly supervised industrial health programs in all communities and with responsibility for implementation resting jointly on management, labor, the medical profession, and organizations concerned with improving the health and working conditions of all wage earners.
4. The endorsement by medical societies of recognized industrial health plans consistent with the platform of the American Medical Association.
5. The establishment of just and equitable remuneration for professional services rendered to industry.

C. Procedure.

1. The committees in the county societies, the committee on industrial health in the state medical society, and the state division of industrial hygiene should confer to establish:
   (a) The lines of relationship and responsibility already existing between government, industry, labor and the health professions.
   (b) The principal industrial health problems of the community as a basis for remedial action.
   (c) The proper organization of local medical and health facilities.
   (d) Supplementary services which can be called on from sources outside the community itself. The needs of small industry should be stressed.
2. All physicians now serving or willing to serve in industry should be invited to meet and discuss the proposed program.
3. Conferences should be held with other professional groups, particularly industrial or public health nurses, industrial hygiene engineers and dentists, in order that arrangements for services provided by these groups may be made.
4. The program should be presented to the executives or representative committees of the manufacturers' associations, and chambers of commerce to determine how the medical profession and the local health departments can accelerate and improve production through appropriate health activity.
5. Cooperation should be secured from local labor organizations. Health education should emphasize particularly nonoccupational factors of importance to the health of workers —oral health, nutrition, housing, proper use of leisure time, recreation and other related activities. Representatives of the local labor organizations should be requested to assume a considerable share of responsibility for the health educational aspects of the program and should meet from time to time with the committees on industrial health of the medical societies for the purpose of receiving guidance and advice.
6. Open meetings should be conducted jointly by the county medical societies and the local manufacturers' associations or chambers of commerce, to which employers, physicians, dentists, representatives of labor, other professional agencies, and, in fact, the community at large should be invited. These meetings will provide means for promoting the program throughout local industry.
7. The activities of the county medical society committees on industrial health fall mainly under four major headings:
   (a) Investigation of local causes of lost time in industry as a basis for necessary remedial service.
   (b) Coordination of community industrial health facilities.
   (c) Frequent education of the public about the benefits of an industrial health program.
   (d) Continuous education of the medical profession as a means of elevating standards of industrial health service.

   In all other ways the committees should exercise that degree of initiative and leadership which will properly represent medicine's responsibilities and opportunities in this important field.

D. Conferences on industrial health to create interest and stimulate common purpose among interested groups.

E. Plant Tours—arranged by industrial health committees with cooperation of medical directors of the local industries.

F. Basic Elements in an Industrial Medical Service.

1. A competent physician who takes genuine interest in applying the principles of preventive medicine, surgery and hygiene to employed groups and who is willing to devote regular hours to such service in the working environment.
2. Industrial nurses with proper preparation, acting under the physician's immediate supervision or under standing orders developed by him.
3. Industrial hygiene service directed at improvement of working environment and control of all unhealthful exposures, to be provided by properly qualified consultants and agencies.

4. A health program which should include:
   (a) Prompt and dependable first aid, emergency and subsequent medical and surgical care for all industrially induced disability in accordance with the statutes governing workmen's compensation.
   (b) Health conservation of employees through physical supervision and health education.
   (c) Close correlation with family physician, dentists, and other community health agencies for early and proper management of nonoccupational sickness and injury.
   (d) Good records of all causes of absence from work as a guide to the establishment of preventive measures.

G. Industrial health programs of medical societies known to be well organized and operating effectively should be studied by other committees. The Council on Industrial Health of the American Medical Association will from time to time draw attention to these successful programs and will act as a clearing house in the exchange of ideas and information between the various committees.

The meeting of the American Academy of Occupational Medicine was also attended recently in Cincinnati and a statement on objectives, scope and accepted methods for occupational medicine was outlined and developed. This is not yet in final form but will be submitted to those concerned in this field on its completion.

LABORATORY MEDICINE

FRANK W. KONZELMANN, M.D., Chairman, Atlantic City

Your Laboratory Committee has completed the resolutions concerning the handling of bodies, especially those which have been autopsied. These recommendations have been approved previously by the Committee on Medical Practice, the Board of Trustees of The Medical Society of New Jersey, the New Jersey Hospital Association, the New Jersey Funeral Directors Association and the New Jersey Society of Clinical Pathologists. These recommendations appeared in THE JOURNAL.

The other projects of this committee have not been brought to completion. No satisfactory action or recommendations can be made concerning the disposal of parts of the body removed at surgical operation. The practice in some hospitals is to destroy these members, removed surgically unless requested by the patient concerned to direct them to a mortician for burial. There seems to be no law which your Committee has been able to uncover regulating the disposition of such members. The matter is still under study.

Publication of a note concerning pre-marital serologic tests has been considered unwise at this time.

No definite progress has been made concerning a lecture series for graduate instruction in laboratory medicine.

MEDICAL CARE OF THE INDIGENT

HAROLD C. COX, M.D., Chairman, Hightstown

With the approval of the Subcommittee on Medical Practice and the Welfare Committee, the following statement is recommended for referral to the county medical societies, marked for their urgent attention for conference with welfare agencies:

The number of families dependent upon public assistance has been increasing in recent months. This means there is a growing need for medical care to be provided by local welfare agencies.

A resolution adopted by the House of Delegates of The Medical Society of New Jersey on April 27, 1949, noted that "certain communities are attempting to supply medical care to welfare patients through one or more designated physicians employed on part time contractual arrangements". The Society's resolution pointed out that "this system has been found to be more expensive to the community and less satisfactory to both the patient and the physician than a free choice, fee-for-service

plan, since it gives the patient the right to choose his own physician and to obtain his medical care under the conditions of privacy and freedom available to his more fortunate neighbors."

A survey of welfare arrangements in individual communities, while incomplete, has provided a picture of the current provisions for medical welfare services in New Jersey. This survey has revealed that a great many communities already have adopted the plan of providing medical care to indigent patients through their own physicians with payment on a fee-for-service basis.

Nevertheless, as was pointed out by the Society's resolution in April 1949, "many communities have not established standards for the recognition of medical indigency, or made arrangements to provide necessary service at public expense to people who, while self-supporting in other respects, are unable to meet the costs of medical and hospital care."

We are now entering the second phase of our program for the improvement of medical welfare administration throughout the state. We propose now to activate the following two purposes endorsed by the House of Delegates in the resolution referred to above, namely: (1) "That each county medical society make every effort to persuade every community to provide medical service to relief patients by the free choice, fee-for-service plan;" (2) "That each county society do everything possible to persuade every community to fulfill its responsibility in providing hospital and medical care for medically indigent citizens."

We urge that, to activate this program, each county society shall, as further requested by the House of Delegates, "appoint an appropriate committee to carry out the above . . . plan of action and to represent the county society in all matters of welfare and medical service, as well as to serve in an advisory relationship to the welfare authorities throughout the county in the administration of these programs."

The twelve-point "National Health and Medical Care Program" recently set forth by The Medical Society of New Jersey proposes that local communities provide voluntary non-profit medical care and hospital insurance for the medically indigent in the community through the use of state and local funds for the purchase of such protection; and also that the local welfare authorities study the possibility of utilizing these plans on a cost basis for the actual provision of required medical and hospital services for indigent persons on public assistance rolls.

In accordance with these policies, this Committee strongly *recommends* that welfare authorities purchase non-profit Blue Cross and Blue Shield insurance coverage for the medically indigent. This will help the communities meet their legal responsibility for providing service for people not on relief but with incomes insufficient to withstand the economic consequences of catastrophic illness.

This would be a tremendous step forward in assuring medical service to those who most need such protection under the same arrangements as are available to their more fortunate neighbors. Also, through the use of voluntary non-profit plans in the manner above proposed, the municipality will be better able to anticipate and provide for medical service at a reduced cost. That the provision of such service on a fee-for-service, free choice plan is more economical and more satisfactory has been proved by several years' experience in many communities, must notably in Newark. The application of the principle of insurance for the medically indigent will mean another impressive improvement in this program.

These objectives can only be accomplished by a determined effort on the part of each county medical society. We earnestly request that such effort be made, with the assurance of the utmost cooperation and assistance on the part of the State Society.

NURSING AND NURSING EDUCATION

H. Wesley Jack, M.D., Chairman, Camden

The Nursing and Nursing Education Committee of The Medical Society of New Jersey participated in many conferences with the New Jersey Board of Nursing, concerning the survey of the state of New Jersey. Representatives of the Nursing and Nursing Education Committee attended monthly meetings of the State Advisory Committee on Practical Nurse Education. These sessions laid the ground work for what we believe will be better nursing care for the citizens of New Jersey.

PHARMACEUTICAL PROBLEMS

John L. Varriano, M.D., Chairman, Jersey City

Three meetings of the committee were held during the year. They were joint conferences with the Committee on Professional Relations of the State Pharmaceutical Association. At the June meeting in Atlantic City steps were taken to promote the establishment of joint committees in each of the counties. Meetings of both professions have been arranged in most of the counties.

A recommendation was made to the Board of Trustees of The Medical Society of New Jersey that a token donation be made to the National Committee on Revision of the U. S. Pharmacopoeia.

Work on the sixth revision of the New Jersey Formulary was started and a new approach adopted. Many of the present monographs will be deleted since they are outmoded. The service of a board of consultants was enlisted with specialists in the different fields of medicine aiding the committee. The completed revision should be available to the members in the fall.

Throughout the year attention has been called to the occasional violations of the federal Narcotic Act by physicians and pharmacists.

The committee has expressed its disapproval of the establishment of pharmacies in physician-owned clinics since they violate the principle of free choice of pharmacists and may lead to coded prescriptions.

The dispensing of medicines by nurses in physicians' offices and industrial plants was condemned in a recommendation to the Medical Practice Committee.

At a meeting with the Subcommittee on Legislation, the problem of the control of antihistaminics was presented. Their potency, dangers, and reactions were pointed out, as was also some fraudulent advertising. It was recommended that restrictions on the sale of these drugs be re-applied either through state legislation or by appeal to the Food and Drug Administration.

PHYSICAL MEDICINE

Elmer J. Elias, M.D., Chairman, Trenton

The Committee has held two meetings during the year and also has met informally at the monthly meeting of the New Jersey Society of Physical Medicine. Progress was made towards the objective of heading physical medicine departments by physiatrists. The best interests of the profession can be achieved through the coordination of sound medical diagnosis followed by proper physical measures. The Committee reiterates its previous recommendation and continues to stress the importance of limiting employment in physical medicine departments to technicians who are physio-therapists registered with the American Physical Therapy Association. To standardize the qualifications of the technicians, it will be necessary that regulations be established for the licensing of physical therapy technicians.

During the past year, the Council of Physical Medicine of the American Medical Association was re-designated the "Council of Physical Medicine and Rehabilitation". Stress is thus laid on the importance of the third phase of medicine—that of getting the patient from the bed to the job.

The Committee requests the Society and its members to recognize the progress made in this field of medicine and to give its support in furthering the service of physical medicine to the medical profession generally.

RADIOLOGY

W. James Marquis, M.D., Chairman, East Orange

During the past year, the committee held three meetings. The first was largely concerned with organization and the problems to be studied during the coming year. Much of the discussion centered about the Hess report, which was presented at the June 1949, meeting of the American Medical Association. The report, as originally presented, was given on page 619 of the June 18, 1949, *Journal of The American Medical Association;* and the action of the House of Delegates is on page 795 of the July 2, 1949, *Journal of The American Medical Association*. It was felt that, in view of this report, steps should be taken by the Committee to initiate some action in the State Medical Society along the lines recommended by the Hess Committee.

The Medical Practice Subcommittee last September indicated that it was expected that eventually payment for all medical services will be transferred from Blue Cross to Blue Shield Plans. These transfers would be made when the enrollment in Blue Shield Plans reaches the number enrolled in Blue Cross Plans. It was the opinion of the Committee that action to force such transfer at this time would be premature. The Advisory Committee on Radiology, therefore, took no further action at their meeting in regard to this problem.

A letter was received from Dr. Brodkin asking for a fee schedule for workmen's compensation cases. In view of the society's repeated reluctance to endorse such schedules, it was decided not to present a fee schedule at this time. Dr. Murphy had asked for a fee schedule for radiologic services to be included with that of other charges to be submitted to the Crippled Children Commission of the State of New Jersey. The Chairman took it upon himself to submit such a schedule, and at the third meeting of the committee this schedule was agreed upon except for a few charges which seemed to be below the average.

Although resolutions had been presented at the previous meeting of the Medical Practice Committee in regard to the Hess report, it was decided to take no further action at this time in view of the fact that the Hess report had been referred back to the American Medical Association for reconsideration.

WORKMEN'S COMPENSATION

William K. Harryman, M.D., Chairman, Hackensack

Considerable progress has been made during this past year in various matters.

We have had excellent cooperation from the Advisory Committee of the Workmen's Compensation of the Department of Labor and they have helped me work out some of the problems that have arisen. We are working out a solution to my supplementary report last year in regard to ill-advised neuro-psychiatric testimony given on workmen's compensation cases. This matter is being adjusted and the Deputy Commissioners already inform me that they are getting some results.

I have no specific recommendations at the present time, but will try to adjust things as they arise.

COOPERATING AGENCIES

STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., Secretary, Trenton

During the calendar year 1949, the Board examined 98 applicants for a license to practice medicine and surgery. Seven of the applicants were graduates of osteopathic colleges. The Board also examined 17 applicants (and passed 12) for a license to practice chiropody. All candidates were full citizens.

TABLE 1.
CANDIDATES FOR MEDICAL LICENSES EXAMINED 1949

Graduate of School in	*Examined*	*Passed*	*Ratio*
Austria	2	1	50%
Great Britain	4	3	75%
Hungary	2	1	50%
Italy	4	1	25%
Poland	2	0	0%
Rumania	2	1	50%
U.S.A. Medical Schools	75	64	85%
U.S.A. Osteopathic Schools	7	5	71%

Two hundred and seventy licenses were issued to applicants for endorsement of a license from another state, or a diploma from the National Board of Medical Examiners, who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined. Of these 270 candidates, 7 were alumni of Canadian schools and 32 had been graduated from European medical colleges.

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals in this country and abroad before a license was issued.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the State now in practice is increasing or decreasing.

Annual registration would give the Board accurate information relative to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiropody and midwifery provide for an annual registration and our records show an increase of five in the number of chiropodists registered on November 1, 1949, and a decrease of fifteen midwives for the same period.

ENFORCEMENT

Following is a brief report of the Board's activities in enforcing the laws which they administer:

COURT CASES—VIOLATION OF MEDICAL, ETC., LAWS (74)

Convicted, Pleaded Guilty or Settled	41
Pending in the Courts	31
Cases Dismissed	1
Cases Lost	1

UNITED STATES SUPREME COURT (2)

Motions to Dismiss Complaint for Declaratory Judgment Granted—Petition, brief and appendix in support of motion for leave to file petition for writ of mandamus to United States Supreme Court served on Governor, Attorney General and Board—Motion denied by Supreme Court of the United States	2

HEARINGS BEFORE BOARD (5)

Medical—Complaint Dismissed	1
Chiropody—License Suspended	1
Midwifery—License Revoked	1
Midwifery—License Suspended	1
Midwifery—Complaint Dismissed	1

TABLE 2.
ANALYSIS OF INSPECTIONS AND INVESTIGATIONS

Total Number of Investigations and Inspections Made	209
Total Number of Visits Made and Treatments Received in Making the Investigations and Inspections	1036
Average Number of Visits per Investigation	4.9

TABLE 3
CLASSIFICATION OF INVESTIGATIONS AND INSPECTIONS

Type of Cases Investigated	*No. Investigated*
Druggists practicing medicine	25
Prescribing herbs and drugs	27
Unlicensed medical doctors	10
Licensed physicians assisting an unlicensed person	2
Licensed chiropodists violating advertisement regulations	26
Unlicensed Chiropodists	5
Licensed chiropractors exceeding license	4
Unlicensed chiropractors	54
Licensed osteopath assisting an unlicensed person	1
Naturopaths	6
Physiotherapists	20
Electrotherapists	1
Massage	4
Unlicensed medical school	1
Medical revocation	1
Midwifery revocation	3
Miscellaneous	19
	209

NEW JERSEY HEALTH CONGRESS

James E. Bryan, Secretary, Trenton

The purpose of the New Jersey Health Congress, as stated in its Constitution, is to facilitate "the interchange of ideas and joint conference studies of the quality, quantity, availability, and distribution of health services rendered by the allied health professions, with constructive recommendations to participating agencies to the end that good quality health services shall be available to all the people in New Jersey".

For several years, the meetings of the Congress have been devoted to the discussion of prepared reports by the professional groups presented in the Congress or presentation by some of the specialized health organizations in New Jersey concerning their activities.

During the present year, effort has been made to solicit the point of view and needs of some of the principal public or consumer groups such as industry, agriculture, labor and women's groups.

Up to the time of writing of this report, two meetings have been held, the first in November, the second in February.

The program for the November meeting was arranged by the New Jersey State Chamber of Commerce, on invitation by the Health Congress. Representatives of the Chamber discussed the employer's point of view concerning hospital and medical-surgical insurance, Workmen's Compensation insurance, and Temporary Disability Benefits.

In February, the program was arranged by the New Jersey Farm Bureau and the meeting was devoted to a discussion of two topics; one, the Hunterdon County Medical Center project as an example of how a rural area can mobilize to meet its own medical and hospital problems; two, the pros and cons of the proposal for consolidated health departments, especially in rural areas.

A third meeting is planned for May at which time a third major consumer group will be invited to present its point of view on current problems.

The New Jersey Health Congress suffered an irreparable loss—as did, indeed, the entire state of New Jersey—in passing during this present year of the founder and president of the Congress, Dr. Stanley Nichols.

The New Jersey Health Congress stands as one of the many monuments to the vision, energy, and spirit of cooperation that distinguished Dr. Nichols. Other officers who have served during the past year were William Perry Watson, Secretary of the New Jersey Farm Bureau, who has acted as First Vice-President; Dr. C. Byron Blaisdell, Second Vice-President; Mr. John J. Debus, Secretary of the New Jersey Pharmaceutical Association, who has acted as Treasurer; and the undersigned, who has continued as Secretary of the Congress.

It is the consensus of the officers and, we trust, of most of the members of the Congress as well, that it serves a valuable and unique purpose as a forum for friendly and constructive consideration of many problems that are of concern to all the agencies and professional groups interested in the health and welfare of New Jersey's citizens.

COUNTY SOCIETIES

ATLANTIC

M. Browne Holoman, M.D., President, Margate City

At this time, it is most difficult to choose words to express adequately my genuine appreciation to the various committees, their chairmen, and the Society as a whole, for their splendid cooperation. I am deeply grateful to all of you for the fine and gracious manner in which you have supported me and the Society.

I have attempted here briefly to outline the salient features of the activities of the Society during my year as president. In such a summary, it is possible to dwell only on the highlights, the splendid work that has been done by all our efficient committees and their chairmen.

The Program Committee, again so ably headed by Dr. Clarence Whims, brought an imposing list of distinguished speakers to our meetings.

To Dr. Louis Rosenberg, I wish to offer my profound thanks for his able assistance and for the fine work he has done in the capacity of secretary of the Society, and to Dr. Daniel C. Reyner, the past secretary for many years, who has rendered invaluable aid to both Dr. Rosenberg and myself.

The Board of Censors with Dr. Sloan G. Stewart as chairman, elected thirteen new members to the Society, three associates, six honorary members, and one courtesy member.

As always, we are deeply indebted to the *Bulletin* staff, with Dr. Edward Guion as its able head, for the fine and outstanding publication they have given us this year. We, as well as they, can be justly proud of their efforts.

This year, confronted with the problem of compulsory health insurance, the Public Relations Committee headed by Dr. Sloan G. Stewart, and Broadcasting Committee, with Dr. Robinson D. Harley as the Chairman, have had a most important function in helping to mold public opinion. A new type of dramatized radio program, entitled "Doctor's Orders" was initiated. These committees have most ably utilized this valuable medium of projecting the medical viewpoint.

I would like to thank Dr. Halvor L. Harley and Dr. Edward Guion who cooperated with him, for their efforts in formulating a plan to honor members of our profession who have been in practice for more than fifty years. This innovation was a small token of esteem and regard in which we hold the colleagues whom we so honored.

Mention must be made of the Society's disapproval of a proposed change in the State Constitution, limiting each component Society to one delegate for each fifty members, instead of each fifteen; of the resolution drawn by the Public Relations Committee, officially placing this Society on record as being opposed to compulsory health insurance; of the Society's approval of the $25,000,000 bond issue to relieve emergency conditions in state institutions.

The passing year saw the formation of a local chapter of the State Heart Association, under the able guidance of Dr. Irving Shavelson and his committee on cardiovascular diseases. The newly formed diabetic committee, under Dr. Morton Major was instrumental in so well publicizing "Diabetic Week", thus furthering the cause of this work.

I take personal pride in the splendid work which has been done by other committees that I have not mentioned; of Dr. Samuel L. Salasin's efforts in promoting the mobile unit survey; of the committee to further Red Cross Blood collecting efforts. Special mention must be made of the diligent and painstaking efforts of our treasurer, Dr. A. Harrison Nickman. As a result of these efforts, our Society ranked high among the leaders in the collection of the special A.M.A. assessment. He is deserving of our sincere gratitude. I would like to express my appreciation to Dr. David B. Allman for the guidance which he has always contributed so generously and graciously, and for allowing us to borrow so freely of his extensive knowledge and experience.

It is with deep regret that I report the passing of two of our esteemed members: Dr. Charles B. Kaighn and Dr. James C. F. McVay. Their loss was inestimable.

The accomplishments of the Atlantic County Medical Society have obviously been numerous and particularly praiseworthy. I consider it a distinct honor and privilege to have served as its president during the past year, and pledge my support and extend my good wishes to my successor.

BERGEN

John L. Olpp, M.D., President, Tenafly

The year 1949-50 marked the beginning of aggressive attacks by the Bergen County Medical Society on three important problems: emergency medical calls, blood supplies, and examination of allegedly drunken drivers.

The first step toward a solution of the emergency call and "drunken driver" examination difficulties was to establish liaison with the police of Bergen County. A joint committee of the Medical Society and the County Police Chiefs Association was organized. The Medical Society is represented in this unit by its Public Relations Committee, headed by Dr. Russell K. Tether, a past president.

A plan for handling emergency medical calls was quickly developed, and a list of available physicians, with more than 100 names, was distributed throughout the county to police, first aid units, physicians' exchanges, telephone exchanges, hospitals, and other strategic points. Physicians were alerted to step up their cooperation, and suggestions were made to police departments to improve their procedures in handling emergency calls. Results, while far from perfect, represent tremendous progress.

To acquaint physicians and police with the problem of apprehension, examination, and prosecution of drunken drivers, the joint Medical Society-Police Chiefs Committee organized a mock trial, attended by some 800 police officers, physicians, and others interested in this problem.

The trial emphasized difficulties of both physicians and law enforcement agencies. Talks by representatives of the two groups further analyzed the problem. One immediate result was a unanimously adopted motion that police departments throughout Bergen County adopt the new, improved, uniform "drunken driving" medical examination forms devised by the Joint Committee. It was agreed that the physicians and law enforcement bodies, through the Joint Committee, continue their cooperative efforts toward the eventual elimination of drunken driving.

Inadequate hospital blood supplies became an editorial issue in the local daily newspaper, and again the participation of the Bergen County Medical Society was needed. A special committee headed by Dr. R. M. Anderson developed a plan for cooperation with the local Red Cross, and this proposed arrangement is now in the hands of the Red Cross, with negotiations between the two groups for implementing the plan, scheduled to begin in the immediate future.

The plan as proposed by the committee provides for a more effective use of present facilities through the establishment of uniform procedures among the hospitals in the handling of blood, and through provisions for the exchange of blood in emergency situations.

It also sets up a "permissive" program of cooperation with the Red Cross, in which the Red Cross would undertake to supply donors to sustain hospital blood banks at adequate levels, and to make this blood available to patients without charge, or for a nominal fee.

The Rh Negative Blood Donors Club, sponsored by the Society, completed its second year in outstandingly successful fashion, through the efforts of its chairman, Dr. Felix H. Vann, and of the Auxiliary to the Medical Society, which handles all the extensive clerical work in connection with the Club's operation. The Club not only met all needs in Bergen County, but on several occasions assisted New York City hospitals, and offered its aid in the Rockville Centre, Long Island, railroad disaster in March 1950.

The fight against socialized medicine was spearheaded by an active Speakers Bureau of Society members, who have carried the message of free and unregimented medicine to virtually every village, hamlet, and town in Bergen County.

A public speaking course for these members, and for new recruits, was held for the second successive year. The work of the Bureau was directed by Dr. Sherburn E. Edgerly until the pressure of other duties forced him to relinquish the post, which has been assumed by Dr. Marshall F. Driggs.

An outstanding graduate course was held at Englewood Hospital under the sponsorship of Rutgers University, with Dr. John E. McWhorter in charge. The course provided up-to-date information on aspects of medical practice most vital to the profession.

Regular meetings of the Society, unusually well-attended throughout the year, have brought eminent authorities in various fields of

medicine to lecture to us in Bergen County. In most cases, there have been presented at each meeting, papers on both the medical and surgical aspects of the problem under consideration.

A report such as this necessarily notes the highlights, and perforce omits much of the solid work performed quietly by committees and individuals throughout the year. Some of this essential spadework must always continue unheralded, but some will develop into highlight material in years to come; notably, we believe, in the field of cancer detection programs made available by individual physicians.

The work of one such essential committee, Maternal Welfare, headed by Dr. Vann, this year made headline newspaper copy in the area, when *the entire twelve months of 1949 passed without a single maternal death in Bergen County.*

We acknowledge the splendid services of our Public Relations Counsel, Randall Norris, who was successful in obtaining extensive newspaper coverage of the activities of the Society. To Mrs. David Boyd we extend the appreciation of the Society for a "job well done".

BURLINGTON

E. Vernon Davis, M.D., President, Moorestown

Subsequent to the Annual Meeting of The Medical Society of New Jersey in April, the elective officers of the Burlington County Medical Society, returned to their local habitat impressed with the fact that there was a definite job to perform during the coming year. Following several committee meetings, the plan for the year's work was to center around four major projects:

(1) To continue to keep our membership informed as to the latest developments in the fields of medicine by continuing with our monthly scientific programs.

(2) To improve upon and expand our local (1-10-20) plan.

(3) To continue the previously formed Speakers Bureau.

(4) To sponsor five Public Health Forums.

Our scientific papers have been exceptional, covering such subjects as: recent advances in hematology; diagnosis and treatment of liver disease; the adrenal cortex; detection of pelvic cancer; recent advances in chest surgery; neurologic signs in general practice; and low back pain.

The (1-10-20) plan, under the direction of our Plan Chairman, Dr. Winfield Betts, has been expanded. Captains have been elected for the five teams which have been formed. Several meetings with lay persons have been held and much information has been dispensed to them, both prepared and unprepared, the latter pertaining particularly to our local problems.

The Public Relations Committee, under the Chairmanship of Dr. William E. Bray, has continued its excellent work in presenting our problems to lay groups as respects state medicine, cancer and other pertinent subjects through the Speakers Bureau. Some half-a-hundred talks have been given to all types of lay groups.

Our Public Health Committee, under the direction of Dr. A. B. Peacock, has sponsored Health Forums in five different communities of the county on diabetes, arthritis, child health, cancer and hospital administration. Although the forums have not been attended as well as desired, we believe we are proceeding in the right direction to impress the public with our deep interest in their health problems.

Our miscellaneous activities began rather acutely upon receipt of a telegram from the chairman of the Legislative Committee of The Medical Society of New Jersey, requesting that we exert efforts to defeat the President's Reorganization Plan No. 1. After considerable effort on our part, many hundred telegrams were sent to Senator McClellan.

Burlington County is proud of its 100 per cent membership having paid the 1949 A.M.A. Assessment. We unanimously endorsed President Norton's "Twelve Point Health Plan".

Misfortune struck our lot in the loss of two of our most respected members: Drs. Russell D. Geary and J. George Wagner. Seven new members joined the Society during the year to date.

CAMDEN

A. M. K. Maldeis, M.D., President, Camden

The Camden County Medical Society is completing its one hundred and fourth year. At the start of the year 1949-50 some serious member losses occurred in the deaths of our president-elect Joseph Lovett and our past-president Thomas K. Lewis. Their unselfish and untiring devotion to their profession will be long remembered.

Non-member physicians in Camden County were approached with the hope of securing them as members. Thirteen new members were added to our rolls and there are two in process at the time of the April meeting. Three members were elected to honorary membership. Losses in membership were three by transfer to other societies, two by death, and one by resignation. Total membership is 265.

Members delinquent in dues have been reduced to a minimum. As a result of repeated notices the payments of the 1949 twenty-five dollar assessment by the A.M.A. have been brought to 90 per cent.

In June 1949, the annual outing was held at Woodcrest Country Club with good attendance. Regular meetings of the Society were held except in June, July, August and September. The Program Committee arranged for excellent speakers or presentations of interesting cases by members. At the January meeting the society was honored by the presence and address of the President of the State Society and in March the State Executive Officer attended and spoke upon current medical problems. Hospital night was held at West Jersey Hospital. Scientific subjects were varied at the meetings, which have been well attended. Guest speakers were entertained at dinner prior to the meeting, according to custom.

Invitations to the Society were in practically all instances accepted and attended. These included the one hundredth anniversary of the Philadelphia County Medical Society. The Inter-Professional Relations meeting of the Philadelphia Branch of the American Pharmaceutical Association, at the Institute for Cancer Research, The Visiting Nurse Society, The Camden County Tuberculosis Association, The Cancer Society, The Council of Social Agencies, The Press Conference of the State Society, The Ventnor Clinic, The Heart Association, Cerebral Palsy, Inc., Red Cross Blood Bank, Student Nurse Recruitment Committee and other activities.

All meetings of the State Welfare Committee were attended by several of our members. The hearings by the Commission on The Habitual Sex Offender, appointed by the Governor, were attended by a representative of the society.

A committee on conservation of vision consisting of the ophthalmologists of the society was appointed to study the needs and supply of eye care in Camden County.

At Christmas the "forgotten few" patients in the hospitals of Camden were visited on Christmas by representation of the membership and presented with gifts and the good wishes of the Society.

A committee was named to work with a committee of the Pharmaceutical Association toward the establishment of closer and better relationship.

The Speakers' Bureau performed creditably under the supervision of the Public Relations Committee accounting for twenty-eight addresses given and six scheduled for the immediate future. These were delivered to various civic groups and clubs. Sixty-one stories for a total of 450½ inches of space and three pictures for a total of 50 inches of space have appeared in Camden County and Philadelphia newspapers and publications. There were also a number of releases by Radio Stations WCAM and WKDN.

The thanks of the Society goes to the women of the Auxiliary for their splendid participation in the Public Relations and other activities.

Study of the situation and problems relative to atomic warfare was suggested. This matter was referred to the Disaster Committee for their consideration and recommendations.

One of the chief activities of the Camden County Society has been its two-fold effort in the fight against government controlled medicine. Part of the method has been the publicity already referred to. The other part has been the encouragement of better public relations by appropriate acts and deeds by the profession and by the display of interest and activity in the many social and civic organizations. During the year there were endorsed and encouraged—The diabetic survey, the county chapter of the Heart Association, The Visiting Nurse Society, The Red Cross Blood Pro-

gram, the Council of Social Agencies, Cerebral Palsy, Inc., and other activities pertaining to the public welfare. Not only has endorsement been given but members of the Society have been named to membership of the boards of these organizations.

A press conference by the Society with the managements of the Camden County news publications is in process and a date in the near future should be shortly announced.

The financial condition of the Society is sound.

Active interest in the affairs of the Camden County Society was shown by the officers, members of the executive and other committees and boards, and the membership in general. Thanks to all. Without the patience and cooperation of the whole Society we would have accomplished nothing. There is still much to be done.

ESSEX

Joseph I. Echikson, M.D., President, Newark

The Essex County Medical Society has devoted most of its activities during the current year to an educational campaign designed to acquaint our members and the general public with the problems of medical care.

We have tried to broaden the viewpoint of our members on problems facing the world at the present time. To do this, our meetings were planned with a viewpoint to bring information by presenting outstanding authorities in these fields.

At our October (1949) meeting we heard Frank G. Dickinson, Ph.D., Director, Bureau of Economic Research, American Medical Association, who spoke on "Why Medical Economics". Our meeting in November was combined with that of the Essex County Dental Society. The topic was, "The Relationship of Some Medico-Dental Problems" and the speakers were Benjamin Saslow, M.D., Raymond T. Potter, M.D., James S. Green, Director, Memorial Clinics, Samuel Charles Miller, D.D.S., Ned B. Williams, D.D.S., George Straussberg, D.D.S., and Moderator Lester W. Burket, D.D.S., M.D.

Mr. Delbert Clark, Director of Education, N. Y. Times, spoke on, "The New Battle for Germany" in December.

In January, "Sex Offenses Against the Juvenile", a subject of current interest was presented by a panel consisting of: Moderator, Joseph Murphy, Chief Probation Officer of Essex County and the speakers: Ralph Brancale, M.D., Joseph G. Sutton, M.D., Miss Dorris Clarke, Chief Probation Officer, New York City Magistrates Courts, Col. Charles H. Schoeffel, Superintendent of N. J. State Police, Trenton, Lt. Arthur Weller, Lientenant of Police, Newark, and Mrs. Florence Price, President, N. J. Education Association. Much favorable comment appeared in the press, indicating that this program by the medical profession was quite timely and also reflected our interest in the present day problems.

Arthur M. Fishberg, M.D., Director of Medicine, New York Beth Israel Hospital and Clinical Professor of Medicine, N. Y. University, N. Y., gave a talk on, "The Renal Insufficiencies, Their Mechanism and Treatment" on February 9, 1950.

In March, Charles S. Cameron, M.D., Medical Director of the American Cancer Society spoke at a meeting held in conjunction with the Woman's Auxiliary of the Essex County Medical Society. "Cancer, A Personal Problem", was the paper he prepared.

On April 13, 1950, we had a meeting to which the public was invited. This speaker was Senator John L. McClellan, of Arkansas, Chairman, Committee on Expenditures in the Executive Department's United States Senate. He spoke on "Trends in Government".

In addition to our regular program, our Society has taken broad interest in and has participated in activities designed to provide health maintenance examinations, diagnostic and treatment services, and hospital service plans evolved and controlled by the Essex County Medical Society in which it is hoped that the municipality and county government can be interested to the point where they can contribute to this program. We have also been very active in working with the Welfare Federation, the Red Cross, the Cancer Society and the Essex County Service for the Chronically Ill. It can be seen, therefore, that our interests have been broad and we hope that they will lead to the successful solution of many of our problems.

GLOUCESTER

Paul Burkett, M.D., President, Woodbury

The Gloucester County Medical Society held regular meetings each month from September to May.

The annual social night was held October 20, 1949. The members of the society were host to their wives and guests at dinner, followed by a display of card artistry by Michael MacDougal, "The Card Detective".

The November and December meetings deviated from the usual pattern in that joint meetings were held with the American Chemical Society of South Jersey and the Dental Society respectively. A scientific paper of common interest was presented at each of these sessions.

The twelve point cooperative health program as proposed by the State Society has received unanimous endorsement.

From time to time throughout the year, members of the society have addressed lay groups concerning the evils of compulsory health insurance.

Ninety-eight per cent of the members of the society have paid their A.M.A. assessments.

Three new members have been elected and two applications have been referred to the board of censors.

Doctor Oram Wood of Paulsboro a society member of many years was elected to honorary membership as of 1948.

HUDSON

Vincent P. Butler, M.D., President, Jersey City

At present in the fourth quarter of the 1949-1950 official year, the carefully organized program of The Hudson County Medical Society rapidly approaches its zenith, with all major activities in full swing.

We are mindful, of course, of the exceptional honor that has come to us this year, in that one of our own, a past-president, is serving as president of The Medical Society of New Jersey and also as vice-president of the American Medical Association. Honors to Dr. James F. Norton cannot but add prestige to his own local society.

Membership in the Society is by far the greatest in its entire history of almost a century, and we are pleased to report that the present administrative year has been distinguished by marked cooperation of the general membership in all its undertakings.

Seven of our scheduled eight monthly meetings, scientific highlights in this area and consequently well attended, have been held at Murdoch Hall, Jersey City. Among guest speakers have been Reginald H. Smithwick (Boston), Philip Thorek (Chicago), Samuel F. Marshall (Boston), Paul H. Holinger (Chicago), and Samuel A. Thompson (New York). Two additional programs have been presented —one by members of our Society, and another, an innovation this year, by the Joint Committee for Professional Relations, the Hudson County Medical Society and the Hudson County Pharmaceutical Association.

For the first time since 1939, our Society this year had the honor of presenting the Fall Clinical Conference of The Medical Society of New Jersey. Basing judgment upon commendatory letters received afterward from all parts of the state, not only were the scientific sessions of the Conference a noteworthy achievement, but the banquet which closed the event furnished further and indisputable evidence of "Hudson hospitality".

In a report of this nature, it would be difficult to do justice to the activities of the numerous standing and special committees. For special mention, however, we select the Cancer Committee, the Diabetes Committee, the Committee for Postgraduate Medical Education, the Public Relations Committee, and the Committee on Constitution and By-Laws.

The Cancer Committee, meeting regularly, has been working in close cooperation with the American Cancer Society in its program of research, service to the cancer patient, and education of professional people and of the lay public on their various levels of interest in the subject of cancer. Not only has our commit-

tee supervised the educational program of the Cancer Society, its members have most willingly and unselfishly participated in the programs presented to various groups throughout the county.

Through its Diabetes Committee, the Society was enabled to contribute to the national program of the American Diabetes Association during October. Our committee arranged for the establishment of diabetes detection centers at most of the hospitals throughout the county in a sincere effort to locate as many as possible of the unknown diabetics in this area. Members of the Committee personally attended the centers during the entire week, and arranged for the showing of special films, as well as for short talks on the subject of diabetes.

Prefacing its activities by an open meeting on November 4, 1949, the Committee for Postgraduate Medical Education swung into vigorous action which resulted in the excellent program now being given by Hudson County Medical Society under the auspices of Saint Peter's College. Over-subscribed in all instances, courses in endocrinology, cardiology, fluoroscopy of the heart, surgical physiology, and surgical anatomy, were begun early in February and will conclude in June. Despite almost unsurmountable difficulties, a foundation firm enough to support the finest in graduate medical education has been laid within the structure of our Society. A program, well conceived and more ambitious in scope, is in the planning for the coming year.

The Public Relations Committee, active throughout the year, has undertaken several important projects, among which, the public speaking training program continues to be the most popular. Participants in this program, although no longer required to pledge themselves to address audiences on the subject of compulsory health insurance, are accepting speaking engagements on this, as well as many other subjects, thereby making a valuable contribution to an expanding public relations program within our Society.

During the past year, the Committee on Constitution and By-Laws undertook the tedious task of clarifying and bringing up to date our Constitution and By-Laws. The work is progressing steadily, and the new edition will soon be in circulation.

Early in the official year, the State Department of Health sought the cooperation of our Society in its attempt to help meet the problem of alcoholism; its aim was to establish a center in Hudson County, with medical assistance from our members. Our Society pledged its support and its assistance in this worthwhile project.

We wish to make special mention in this report of the excellent relations that continue to exist between our county society and our legislators, both state and national, through the efforts and cooperation of the Legislative Committee of the State Society.

We are proud to record, also, in this report, the meritorious service to us, and also to the county in general, of our Woman's Auxiliary. Besides being most helpful in several undertakings of its parent society, the Auxiliary formulated and carried out an exceptionally ambitious program of its own. Its open health meeting on March 6, 1950, for example, was an achievement of which any organization might be proud. The School Health Program, instituted by The Medical Society of New Jersey, has received full support of the Woman's Auxiliary, and is being promoted in those municipalities where it does not already exist.

Since the last Annual Meeting, we note, with regret, the passing from our midst of seven members—namely, Dr. Morgan Jones, Dr. Archibald E. Olpp, Dr. Joseph A. Murray, Dr. Claudio E. McNenney, Dr. Abdon V. Piskorski, Dr. Carmine J. Cufari, and Dr. Pellegrino A. D'Acierno. (Dr. McNenney and Dr. D'Acierno were recent past-presidents.)

Our Annual Dinner was held at the Biltmore, New York City, on April 15.

Following our own Annual Meeting on May 2, we look forward to the closing event of the official season of the State Society, its Convention on May 22, 23 and 24. In the past, Hudson County Medical Society has had complete representation on its delegation, and it is anticipated that this year it will measure up to its past record.

In closing, may we say that it has been our desire, as members of the Hudson County Medical Society, to cooperate fully with The Medical Society of New Jersey, in accordance with the principles of the American Medical Association, to which we heartily subscribe—as evidenced by the fact that 99 per cent of our members paid the 1949 assessment of the national organization.

My sincere and most heartfelt thanks to all those who helped make the accomplishments of the past year possible.

HUNTERDON

John B. Fuhrmann, M.D., President, Flemington

Our society has only four meetings each year. This year our meetings were devoted mostly to routine business matters following which we had some noted speakers to discuss topics which were of interest to all members. All of these meetings are adequately covered in the monthly reports and have already been published in The Journal.

We have nothing outstanding to report at this time for further publication. In the very near future our hospital plans will be of interest but they have not progressed far enough at the present time to warrant publication.

MIDDLESEX

H. P. Fine, M.D., President, New Brunswick

Congestive heart failure, medical experiences in Mexico, "New Legend drugs", carcinoma of the pancreas and pneumonectomy represented some of the scientific fare served to members of the Middlesex County Medical Society during 1949. Social highlight of the year was the annual meeting in December at which the current panel of officers was elected, and at which the members enjoyed the annual banquet. As usual, Middlesex County continued its pioneer project—a joint meeting with the pharmacists. This year the joint session was held in November and featured a talk by the secretary of our state board of pharmacy. The distinguished New York University Professor of Therapeutics, Dr. Arthur DeGraff was our guest speaker in January. Middlesex was well represented at our state society's Annual Meeting in April. The year 1949 was one of progress for Middlesex County doctors, and thanks are hereby expressed to the fellow-officers and committee personnel whose loyal labors made this progress possible.

MONMOUTH

Harry R. Brindle, M.D., President, Brielle

The fight against socialized medicine has been carried forward during 1949. This has been increasingly more difficult now that the urgency of impending government action is less. Without the spur of necessity and without an effective easily obtainable voluntary insurance plan to offer the public, we have been forced, at times, to pass up excellent opportunities to present our cause. Until Blue Cross and Blue Shield are more easily obtained through individual enrollment, we have not solved the problem of combatting socialized medicine.

During the past year, scientific programs which were both timely and instructive were presented as follows:

"Tracer Technic in Medical Research."
"Pre- and Post-Operative Care."
"Information Please on Cancer."
"Oral Tumors."
"Office Neurologic Problems."
"Poor Risk Surgical Cardiac."
"Recent Advances of New Antibiotics in Medicine and Surgery."
"The Pulmonary Cripple."

The disaster and blood bank committee is sponsoring the organization of volunteer blood

donors to assure an adequate replacement program for the two blood banks now operating in the county. To avoid the abuse of small groups of donors (a factor common in the experience of blood donors in the past) the plan, called "Donors Anonymous", provides that a sufficient number of persons be enrolled so that none will be called upon more than once in every three or four years. The plan protects the donor because their names are known only to their local chairmen. Members of the committee enlist the active support of prominent lay leaders in the enrollment of donors by groups, such as churches, civic clubs, first aid squads, fire and police departments, labor unions, veterans organizations, women clubs, et cetera.

As a result of recommendations made by the Tuberculosis Committee, definite steps have been taken toward providing facilities at four locations in the county. By using facilities available in the hospitals for this purpose, an adequate program will be provided at a minimum cost and inconvenience to the public.

At a joint meeting of our Public Health Committee and the Communicable Disease Committee of the County Health Officers Association, recommendations as to uniform procedure by local Boards of Health were agreed upon and adopted with special attention to the problems presented by the operation of day camps, schools, and swimming pools.

The Public Relations Committee, through its various subcommittees, was unusually active the past year. The program of "round-the-clock" emergency medical service, inaugurated July 8, 1948, continues to function smoothly. Speakers on scientific subjects and socialized medicine were provided by the Speakers Bureau for civic clubs, PTA's, church groups, and other organizations.

The "1-10-20 Plan" Committee has kept our membership informed as to the responsibility of each physician in this phase of the national educational campaign and has attempted, through frequent comment in the *Bulletin,* to stimulate concerted action at the grass roots.

Particularly worthy of note in the field of public relations, is the accomplishment of the subcommittee on Professional Relations. In cooperation with a similar committee of the Monmouth-Ocean County Pharmaceutical Society, a joint committee was formed, providing the means for discussing mutual problems and mutually desirable objectives.

In accordance with the request of The Medical Society of New Jersey, our Committee for the Medical Care of the Indigent conducted a survey of publicly supported medical services in the county and submitted a summary of the findings to the State Society. A postal poll of our membership was taken to bring up to date our listing of physicians who provide care to indigents under the agreements between the county medical society, the county welfare board, and the State Board of Child Welfare.

A committee composed of five of our members was appointed to survey medical facilities and services at the County Welfare House. This Advisory Committee to the Monmouth County Welfare Board, after surveying medical facilities at the Welfare House, submitted a report of findings and recommendations for improved medical service at the institution.

Our Cancer Control Committee and Cardiovascular Committee both present excellent records as regards participation in the expanded program of service and education as conducted by the county chapters of the American Cancer Society and the American Heart Association.

In like manner, our Crippled Children Committee deserves commendation for their participation in the service program of the local chapter of the National Foundation for Infantile Paralysis.

Our School Physicians Committee has directed its major efforts to furthering the "Ten-Point School Health Program" of the Monmouth County Better Health Council.

As usual, the assistance of the ladies of the Auxiliary has proved to be most valuable. This opportunity is taken to express the appreciation of the Monmouth County Medical Society for the cooperation of the Auxiliary throughout the year just past.

During Christmas week, in conjunction with the Woman's Auxiliary, the first annual midwinter dinner dance was held. This proved very successful and provided an opportunity for the new members to become acquainted with the Society and each other. (New members comprise approximately 30 per cent of the total membership of the Society). A similar social affair is contemplated for the coming summer.

We were privileged to have as our guests at one of our regular monthly meetings, Dr. James F. Norton, state president, and Mr. James E. Bryan, state executive officer, who acquainted us with the projects of the State Society and the progress and apparent effects of the national educational campaign.

OCEAN

Harvey Rinzler, M.D., President, Toms River

The Ocean County Medical Society was the first county society in 1950 to hold a full dress press conference. On January 23, the members of the county society and their wives entertained representatives of all but one of the newspapers within Ocean County.

The panel of experts, selected by the county society to respond to the questions from the press, comprised Drs. Ralph Appleton, William E. Dodd, Bernard W. Gartlan, Gorman Jaffee, and Mr. James E. Bryan, Executive Officer of the Medical Society. Dr. Harvey Rinzler, president of the county society, acted as moderator of the discussion.

Following a dinner, the press conference was convened and a lively session of questions, answers, and general discussion followed until late in the evening. Occasionally, the tables were turned and doctors in the listening audience fired questions at the press.

Three principal conclusions seemed to be generally accepted as a result of the discussion. First, that there is need for better dissemination of information among the public generally as to the health services and facilities available in Ocean County; second, that it is desirable that the county society designate a single officer as a point of reference for newspaper editors in reporting and interpreting medical events; and third, that such conferences as this are valuable in the interest of improving mutual understanding between the medical profession and the press.

UNION

Frederic W. Lathrop, M.D., President, Plainfield

Last November we obtained larger office space which we needed very much and our meetings can now be held in more comfortable quarters.

We have 476 active members and seven emeritus members in the Society. Twenty-two new members were elected last year and six members transferred to other societies.

Our weekly radio broadcasts are continuing by request and the program started on its second year, March 6. Our Speakers Bureau has had a very busy season with more than 80 talks given before various groups and organizations. One of our officers gave a talk on public health which was accepted as an accredited lecture in the course on sociology given at the Junior College in Cranford.

Our Legislative Committee has also had a most active season and Dr. Burritt, chairman, has made trips to Trenton and Washington, to keep the members better informed on matters of concern to our profession. While Senator Smith and Senator Hendrickson are in Washington the medical profession has two staunch workers in behalf of the health and welfare of our people. We hope that our members will write to them to thank them for the help they are rendering. We know that they appreciate your letters of commendation as that is the only way they have of knowing that the hard work and long hours they put in in our cause is realized.

A few months ago, Dr. Harry Bloch, chairman of our Cardiac Committee, brought about the organization of the Union County Heart Association and he was elected president. The Association plans a very extensive program in the near future.

A committee has also been formed to plan the organization of a County Health Council in order that the work of the many health and welfare agencies may be coordinated to better advantage to all.

A cerebral palsy committee was appointed this year and is comprised of the physicians who work in the clinic which is maintained for cerebral palsy children at the Alexian Brothers Hospital. The committee was appointed to

assist the Union County Cerebral Palsy League with their medical problems.

The Emergency Medical Service is now in its second year and still averages about 30 calls per month. The Summit *Herald* recently featured an article on this service.

As president of the County Society and State Chairman of the American Pediatric Society, I was invited to attend with Dr. C. G. Hanson, chairman of our Child Health Committee, a meeting to discuss plans for the annual meeting of the Union County Youth Welfare Council. This year the council has been asked by the Governor's Committee on Youth to work with it in gathering material for the White House Conference on Children and Youth in Washington in December.

The Program Committee has had exceptionally fine speakers for our scientific sessions. The committee with the Public Relations and Public Health Committees sponsored a Public Health Week Program last November. The programs were presented in Plainfield, Summit and Elizabeth. Health exhibits were shown during the day by the many health organizations in the county and in the evening members of our Society had discussions on cardiology and cancer. While the attendance was small we feel that the program was well worthwhile.

The Woman's Auxiliary has given us their full support in all of our programs and particularly in matters on legislation. The 1-10-20 Committee rendered invaluable service on the several emergency calls we made on them on legislative matters. Last summer when we had to contact nearly 200 of our members, the Auxiliary made the contacts for us in less than three hours! We are very proud of the commendations they have received from the State Auxiliary for the fine work they have done also in public relations. The members of the Society sincerely appreciate the full support and cooperation they receive from every member of the Auxiliary.

Miss Rogers continues her activities in all matters of interest to the medical profession and sees that all routine administrative work in the executive office is carried out smoothly and efficiently. She is the secretary of the Union County Heart Association and as president of the Soroptimist Club of Elizabeth had the pleasure of attending the capping in March of the first student nurse on a scholarship from the club. During the A.M.A. meeting last June Miss Rogers attended, for the first time as a member, the Medical Executive Officers Conference where the executive staffs of the national, territorial, state and county medical societies discuss their problems and projects. These yearly meetings with the exchange of ideas enable the members to render better service to their own associations. Last December Miss Rogers also broadcast a program on "*Your County Medical Society*" over station WPOE.

We are now completing our group enrollment for the Hospital Service Plan of New Jersey and anticipate that instead of the 40 per cent needed we will have at least a 50 per cent membership enrollment.

I hope that all of the delegates will attend the annual meeting of the State Society and that as many of our members as possible also attend the meeting. I know they will gain much knowledge and information there. To all of the officers and members, I wish to express my appreciation for the assistance given me this year in carrying out the work of the Society and for attending the many meetings necessary to that end.

BOOK REVIEWS

(Continued from page 256)

The Eye and Its Diseases. Edited by Conrad Berens, M.D. With 436 illustrations. 2d ed. Pp. 1092. Philadelphia 1949, W. B. Saunders Company. ($16.00)

The Eye and Its Diseases, a truly remarkable publication, is written by 92 international authorities and is most competently edited by Dr. Berens. Specialists in eye pathology have written the section on pathology; outstanding eye surgeons have written chapters on surgery of the eye, et cetera. Each chapter is concise, comprehensive and detailed. It includes all advances in therapeutics and surgery. Many erroneous ideas and theories present in older textbooks of ophthalmology are corrected. This huge volume is not intended for medical students but it is an excellent book for ophthalmologic residents and graduate students. And the ophthalmologist will find the work particularly useful as a reference tool and a comprehensive review of the entire field of ophthalmology.

I. V. Berney, M.D.

SUPPLEMENTARY LIST No. 2 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Abbamonte, Louis W., 226 N. Park st., E. Orange(7)
Abraham, Albert, 15 Altamont Ct., Morristown (14)
Ambrose, Freder'k H.,Jr.,304 E. High st.,Bd.Br'k(18)
Arndt, Frank R., 7500 Bergenline av., N. Bergen(9)
Atkinson, John M., 93 Greenwood av., Madison (14)
Bailyn, Emanuel, 400 60th st., West New York (9)
Balakian, Gerard, 131 Ayers Ct., West Englewood(2)
Barone, Francis A., 94 Lembeck av., Jersey City (9)
Bauman, Abraham H., Main st., Stirling (20)
Bebbino, Anthony, Springfield av.,Berkeley Hts.(20)
Bentley, John, Jr., 815 Salem av., Elizabeth (20)
Berger, Harold R., 250 Elizabeth av., Elizabeth (20)
Bielski, Johannes F.,180 Somers't st.,N.Brunsw'k(12)
Black, Max S., 1320 St. George av., Linden (20)
Booth, George R., 219 Highland av., Westville (8)
Borchek, Arthur R., 7523 Broadway, N. Bergen (9)
Braitman, Max, 412 60th st., West New York (9)
Breen, James E., 418 Chestnut st., Union (20)
Breitstadt, Charles A., 157 Elwood av., Newark (7)
Brotman, Harry, 808 So. 11th st., Newark (7)
Brown, Edward V., 9 Park av., Caldwell (7)
Calabrese, D. John, 114 Rochelle av., Rochelle P.(2)
Cangemi, Vito F., 50 Glenwood av., Jersey City (9)
Canright, Cyril M., 34 Springfield av., Cranford (20)
Carleton, Charles K., 266 So. Main st., Wharton (14)
Carlin, Edward J. M., 1423 Irving st., Rahway (20)
Carlucci, Angelo M., N.J. State Village,Skillman(18)
Carroll, Thomas R., 754 Anderson av., Grantwood(2)
Cerreto, Frank R., 395 Roseville av., Newark (7)
Cohn, George M., 867 So. 11th st., Newark (7)
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BOOK REVIEWS

Congenital Anomalies of the Heart and Great Vessels. Edited by Paul Cannon, M.D. Pp. 68. Springfield, Ill., Charles C. Thomas, 1948. ($4.50)

The collaborators have assembled clinicopathologic material from 132 cases of congenital anomalies of the heart and great vessels. These demonstrate the anatomy and silent clinical features of sixteen such anomalies. The material is beautifully illustrated and clearly demonstrated. The photographs and diagrams simplify pictorially the often complicated verbal descriptions of these anomalies. Especially meritorious and significant is the essentially small yet select list of suggested readings in congenital cardiac disease. The monograph is a valuable adjunct to more complete works on congenital heart disease.

HENRY GREEN, M.D.

Atomic Medicine. Edited by Charles F. Behrens, M.D. Pp. 416. New York, Thomas Nelson & Sons, 1949. ($7.50)

The title of this timely and remarkable book may be forbidding or enticing according to the reader's likes or leanings but its timeliness introduces a compelling element to its priority on a reading list. Its style and format make compulsion unnecessary once one starts the first chapter. Captain Behrens wrote four chapters himself and is aided in the filling out of the book by radiochemists, physicists, and physicians among whom are numbered C. F. Geschickter and Shields Warren.

Starting with the physical concepts, the book is developed through the popular subject and the relatively well-known data on the atomic bomb and its effects, through the pathology of ionizing radiations. Explanation of the new concepts of atomic structure and its relation to energy are made clear. Tables of "transmutation" of elements from ordinary to isotope forms are available and a minimum of mathematics is introduced for a subject which has such important mathematical groundwork. The fundamental biology of ionizing radiations, the pathology of total body irradiations, hematology and a discussion of radiation illness are chapter subjects. Radiologic safety with relation to x-rays and isotopes as well as atomic disaster planning are dealt with in other chapters.

More than a simple enumeration of contents is necessary to explain the real fascination of this book. Here under one cover there is combined the gist of nearly all the recent literature plus a properly aligned summary of all popular articles of a nonmedical nature from which the average physician might have gleaned his information. In one book a man's eyes may be open to a subject so startlingly new and vast that it fairly takes one's

breath away. For the newer physical concepts, as well as the pathology, and for the calm philosophical attitude always to be attained through clearer understanding, this book should be read and studied by everyone who may possibly have the ability to digest its contents.

Everett O. Bauman, M.D.

Electrocardiography; Fundamentals and Clinical Application. By Lucius Wolff, M.D. Pp. 187. Philadelphia, W. B. Saunders Company, 1950. ($4.50)

Dr. Wolff, of Wolff-Parkinson-White renown, has transferred to the printed page an exceptionally clear presentation of the principles of electrocardiography which he has been teaching at Harvard for the past several years. The author is to be praised for the intelligible way in which the electrical and conduction properties of cardiac muscle are outlined, as well as for his clear handling of such electrocardiographic concepts as dipoles, intrinsic and intrinsicoid deflections, vector analysis, and the precardial and unipolar leads. Ventricular gradients, bundle branch block, hypertrophy and currents of injury are equally well elucidated.

The second section of the book deals with clinical interpretation of the electrocardiogram and covers bundle branch block, ventricular hypertrophy, myocardial infarction, pericarditis, pulmonary embolism, and concludes with a chapter on the W-P-W syndrome. In this section, the diagrammatic technics of Drs. Blumgart and Schlesinger, of the same hospital, are drawn upon to illustrate the clinical problems involved.

Rowland D. Goodman, 2d, M.D.

Meaning and Content of Sexual Perversions by M. Boss, M.D. Translated by L. L. Abell, Ph.D. Pp. 152. (New York, Grune and Stratton, 1949).

To most American readers, the author's doctrine will be challenging rather than acceptable. Boss rejects the orthodox analytic concept of the perversions, contending that the freudian doctrine is too mechanistic, too "objectifying", and too much based on a presumably false assumption that psychic life can be understood in terms of exact scientific concepts. On the contrary, he feels, perversion cannot be interpreted without a profound understanding of love. And "love" implies more than simple relief from sexual tensions, or even unconscious identifications with a father or mother person. Love has to be understood in an artistic, almost poetic sense, as a mode of unearthly and infinite existence—something transcending the narrow limits of earth-bound life. Hence an "existential" kind of analysis is needed: and the author's technic is labelled *Dasein* analysis, which—if translatable at all—can be translated only as "existential analysis". In Boss' own words, "a perversion is thus an expression of a disturbed dialectic between the mode-of-being in love and of being-in-the-world". In the perverted person, the worldly mode of existence is surrounded by barriers, across which love can penetrate only through "apertures". Presumably when love has to be moulded to squeeze through those apertures, a clinical perversion may result.

The concepts are exceedingly difficult to grasp—at least for orthodox psychiatrists accustomed to the neat structuralization of the personality and to the smooth dynamism of the libido. The book is hard reading. One has to go through it slowly, rereading many sentences to absorb the meaning. The vocabulary is unfamiliar and such terms as "love transparency" or the "supraterrestial richness" are not part of the common currency of American psychiatric language. However, it does provide food for thought, the palatability of which will depend somewhat on the state of the reader's intellectual digestive apparatus. Unfortunately Boss does not actually describe his analytic technic, so that his methods cannot be tested by a practitioner whose knowledge of *Daseinanalyse* is based only on this book. Incidentally, this is the only modern psychiatric treatise I have seen which never once mentions the words "ego", "superego" or "id".

Herbert Boehm, M.D.

1949 Year Book of Drug Therapy. Edited by Harry Beckman, M.D. Pp. 718. Copyright 1950 by Year Book Publishers, Chicago. ($4.75)

The postwar renaissance of drug therapy has been one of the interesting medical developments of the century. When I was a medical student (which was in the 1920's), emphasis was on surgical procedures, physical therapy, climatology, good nursing care and dietetics. They were pessimistic about drugs. The old virtues that once attached to tonics, elixirs, alteratives and sedatives had decayed. And the potentialities of chemotherapy and antibiosis had not yet been realized. This area of pharmacologic nihilism seems to be drawing to a close. The physician's problem today is one of selection from a large armory of complex synthetic drugs. In the old days the chemical names were short and simple—epinephrine, acetyl salicylic acid, amphetamine and so forth. Today the chemical names are unrecallable jaw-breakers, and it is necessary to use the trademarked names for most of the modern synthetics. This need has forced medical journals and books to open their pages to the familiar trademarked names, a policy which has made possible a volume like this *Year Book of Drug Therapy*.

Dr. Beckman has arranged the drugs by specialty, so that the allergist, the cardiologist, the pediatrician, et cetera, can each find collected in one chapter, the newest reports on drug treatment in his field. This arrangement makes it hard to follow one drug in all its ramifications, but an excellent index neutralizes that defect. Within each specialty, and for each drug, the significant articles of 1949 are readably abstracted. The editor frequently punctuates the monographs with his own comments, inserting much needed warnings as to toxicity, when that is necessary, and coordinating the author's findings with other reports. This handy volume will be a frequent life-saver to the busy physician who knows that a certain drug is indicated and who wants, in a hurry, the necessary data as to dosage and contra-indications. The alert practitioner will keep it close to the side of his desk on which his prescription pad rests.

Henry A. Davidson, M.D

Additional Book Reviews on page 258

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **May, 1950** **No. 5**

HISTORICALLY, tuberculosis has been a predominantly urban disease in the United States. Associated with poverty, congested housing, poor nutrition, and overexertion, tuberculosis has taken its greatest tolls in the slums of the big city. The decline in the tuberculosis death rate since 1900 has been due in the main to urban developments among which are improvement in living standards and the isolation and treatment of cases in hospitals. In the meantime, what has been happening to tuberculosis in rural areas?

TUBERCULOSIS AND ITS CONTROL IN RURAL AREAS

Exact figures on tuberculosis in rural areas are not available. The recording of deaths in the United States before 1937 was by place of occurrence, not by place of residence. As hospitalization of the tuberculous in sanatoriums, usually located in country districts, increased, more deaths were artificially credited to rural places. Census Bureau definitions of "rural", moreover, have been changed as has the accuracy of death reporting in country districts. Despite these limitations, certain general trends in the tuberculosis death rate, as between cities and rural districts, are evident.

Rural and Urban Tuberculosis Death Rates

While tuberculosis mortality has been declining in urban and rural sections alike, it is probable that the rate of decline in the cities has been greater than in the country. In 1890, when hospital deaths were too few to influence the rural-urban comparisons substantially, the death rate for pulmonary tuberculosis in the cities of registration states was 62 per cent higher than the rate in the rural parts of these states. The differential fell to a total urban rate (49.4 per 100,000) only about 20 per cent higher than rural rate (41.3 per 100,000) in 1940.

Accurate urban and rural tuberculosis death rates cannot be determined for any year since 1940. It is estimated, however, that the approximate urban tuberculosis death rate in 1946 was 38.7 per 100,000 and the rural rate 34.9. These figures represent a further decline of the urban rate at a more rapid pace than that of the rural rate.

Even in 1940, the rural tuberculosis death rate was higher than the urban in certain demographic groups. The rural death rate for white females is actually higher than the urban at all ages from 15 years up. Among nonwhite females, the rural death rate exceeded the urban at ages above 54 years. Among males the rural death rate exceeded the urban in the highest age groups.

These findings illustrate what happens to the tuberculosis death rate in sex-age groups least subject to frequent epidemiologic contacts. Of the various groups, white women have the least contact with the general population. Among aged persons, contact is also likely to be minimal. In other words, among groups with the fewest epidemiologic contacts, the rural death rate from tuberculosis is already higher than the urban. Case finding and isolation of active cases from a community reduce epidemiologic contacts. As these steps are taken in the cities, we may expect the curves for urban and rural tuberculosis death rates ultimately to cross, with urban rates becoming lower than rural for all age-sex-racial groups.

Rural Life and Tuberculosis

Controlling tuberculosis in rural America is made difficult by the same factors that impede the provision of general public health and medical services. Low per-capita income and low population density, with concomitant deficiencies of medical personnel, facilities, and health agencies, create handicaps in the battle against tuberculosis as against most diseases.

The central fact that characterizes the approximately 55,000,000 Americans living in rural areas, as compared with city-dwellers, is lower average family incomes. Citation of only the most obvious of the elements entering into a standard of living —education, housing, nutrition and the use of labor-saving devices—reveals the basic distinction at rural and urban levels. Rural educational levels, including education on personal hygiene and living habits, are woefully below the urban. It may not be so widely recognized, but the Census Bureau figures show that average rural housing is actually more congested than urban. Rural families are larger than urban and acres of land around a home do not add space to the rooms in which the family eats, sleeps, and lives.

The relevance of this to the problem of tuberculosis would seem to be this: if tuberculosis is the classical "social disease" the socio-environmental factors contributing to its occurrence are, with one important exception, epidemiologic contacts, found most strikingly today in rural parts of the United States. Except for the increased opportunity for the person-to-person spread of tubercle bacilli in the cities, the conditions of rural life in America today provide the basis for a higher tuberculosis mortality than do those of urban life.

Measures for Urban and Rural Tuberculosis Control

The measures for reducing epidemiologic contact with unrecognized cases of tuberculosis which are being employed in urban areas are case finding through private physicians, public health tuberculosis clinics, and mass X-ray surveys, and isolation of cases through hospitalization. There are special handicaps to all these measures in rural America. Yet if rural tuberculosis is to be reduced, comparable measures of control are necessary.

The Rural Challenge

As living conditions improve, and effective case finding, treatment, and isolation of patients reduce the prevalence of tuberculosis in the cities, the task of final eradication of the disease in the rural areas must be faced. Present trends point to the time when tuberculosis may become the predominantly rural problem that typhoid fever, once an urban scourge, has become today.

The lesser epidemiologic contacts of country-dwellers is a distinct advantage in fighting the disease. While it may be harder to find cases among rural people and harder to get them isolated and treated, the channels of person-to-person spread are fewer.

The attack on rural tuberculosis cannot be effective unless it is launched on all fronts of rural health service. Rural housing, education, nutrition, and general living standards must be elevated. The services of competent physicians must be available for the everyday care and prevention of illness and hospital services must be expanded as needed. Public health agencies must be extended and X-ray services for periodic chest check-ups must be made accessible. Social measures for the families of persons disabled with tuberculosis must be provided.

Unless these steps are taken, we may expect a permanent reservoir of tuberculosis to smolder indefinitely in rural districts. With these steps taken in city and country alike, tuberculosis can be eradicated from America.

Tuberculosis and its Control in Rural Areas, Milton I. Roemer, M.D., M.P.H., Public Health Reports, October 7, 1949.

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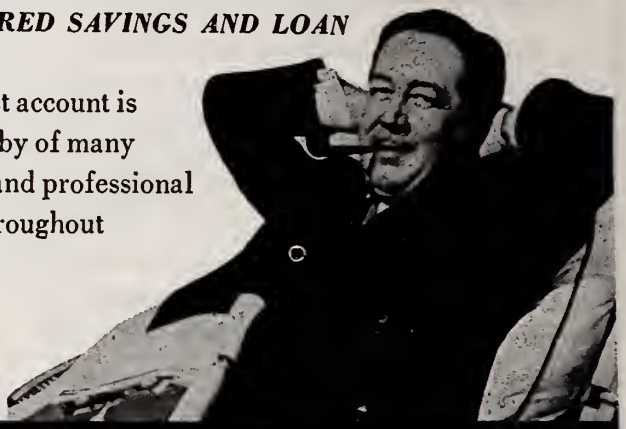

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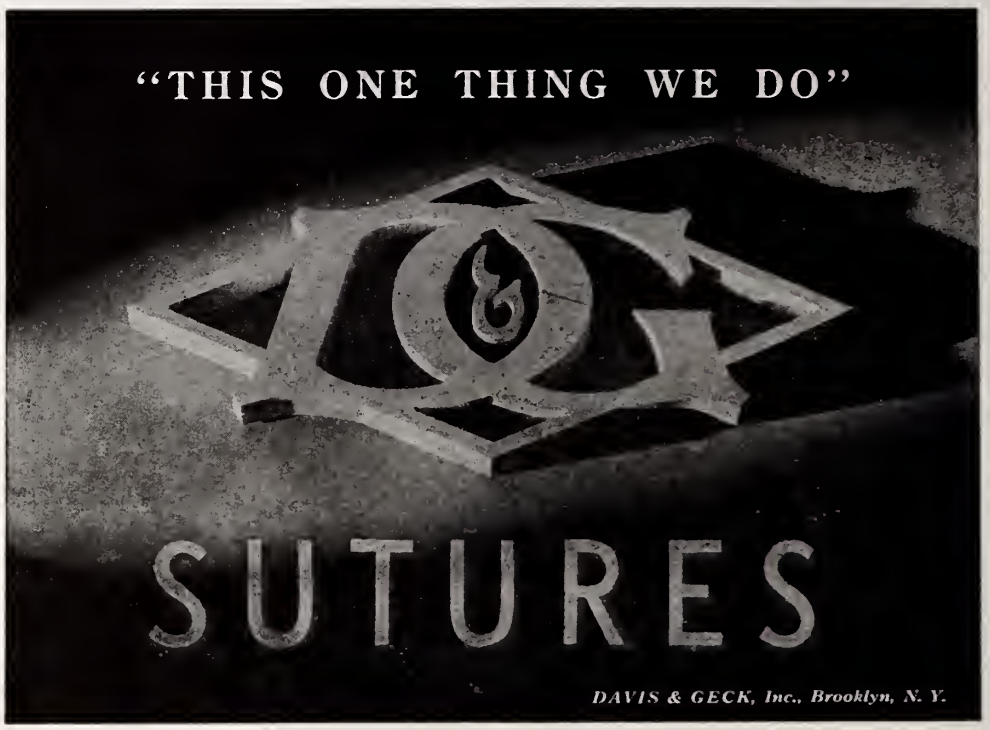

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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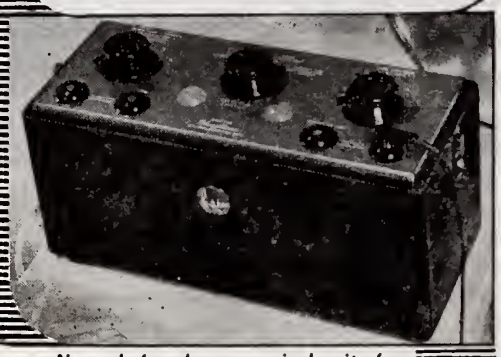

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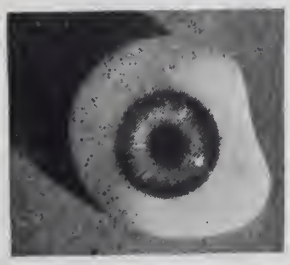

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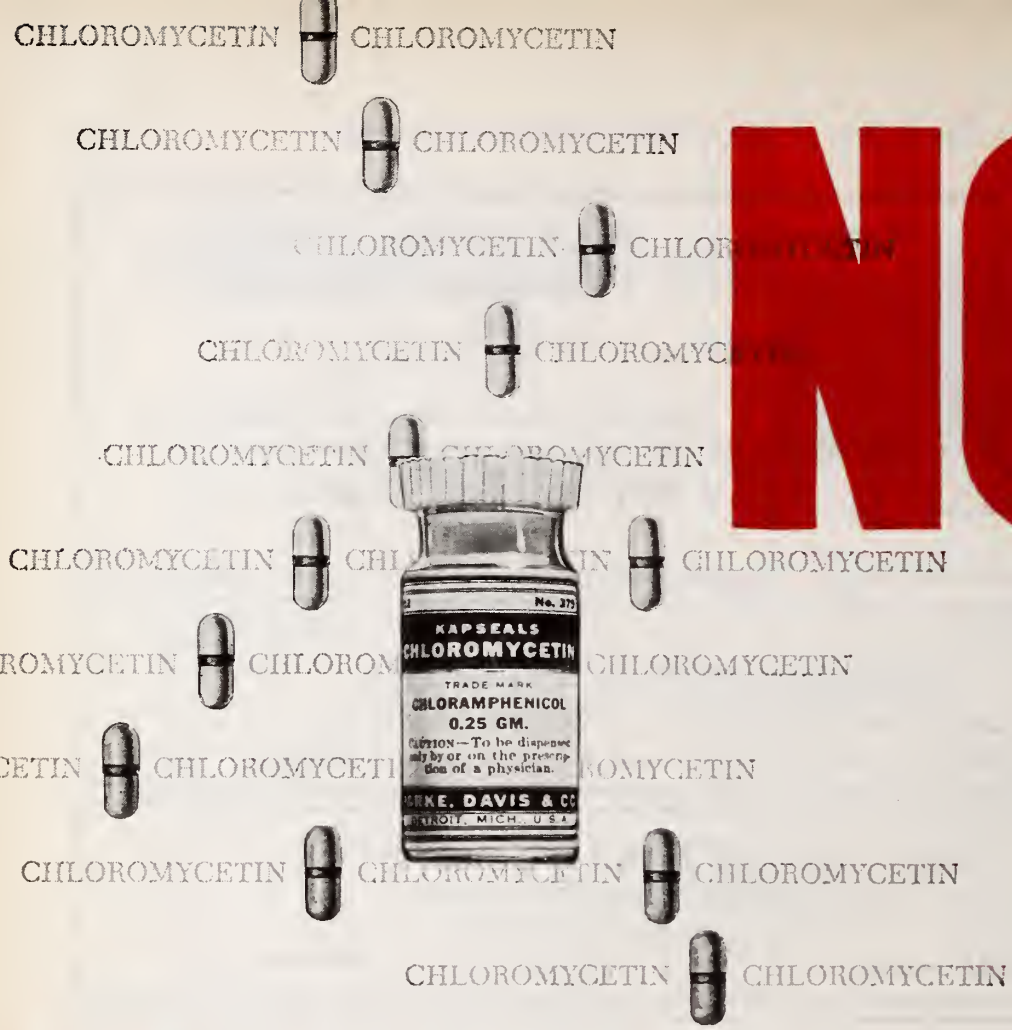

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Smadel, J. E.: J.A.M.A. *142*:315, 1950 (discussion)

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Hewitt, W.L., and Williams, B., Jr.: New England J. Med. *242*:119, 1950

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Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. *51*:68, 1948

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Ley, H. L., Jr.; Smadel, J. E., and Crocker, T.: Proc. Soc. Exper. Biol. & Med. *68*:9, 1948

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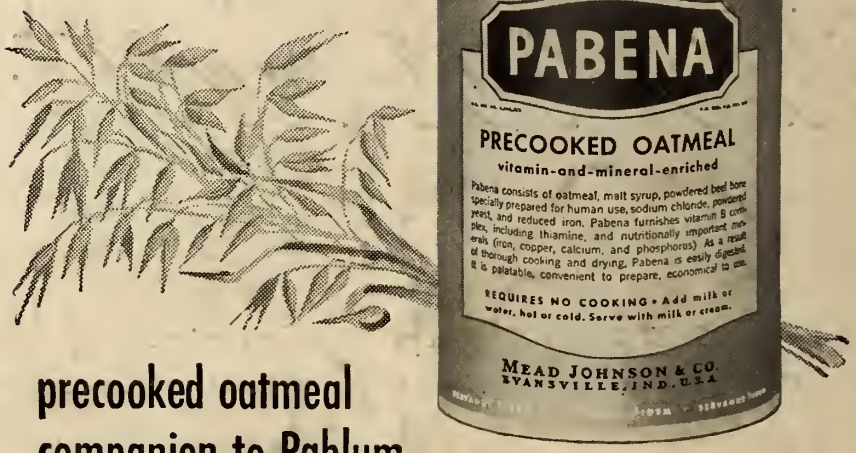

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CONTENTS—Pages 259 to 310

EDITORIALS— Page

OUR NEW PRESIDENT 259
PRESIDENT'S INAUGURAL ADDRESS 260
NEW JERSEY CANCER CRUSADE COMMENDED..... 261

ORIGINAL ARTICLES—

WHY MEDICAL ECONOMICS?—Frank G. Dickinson, Ph.D., Chicago, Illinois 262
NICOTINIC ALCOHOL IN PERIPHERAL VASCULAR DISEASE — Otto Brandman, M.D., Newark, N. J., and Walter Redisch, M.D., New York, N. Y. 267
REHABILITATION IN ACTION—James F. Gleason, M.D., Atlantic City, N. J. 270
SARCOID SPLEEN WITH THROMBOCYTOPENIC PURPURA—Meyer Notkin, M.D., Frederick M. Offenkrantz, M.D., and Anthony Abramo, M.D., Paterson, N. J. 272
MANAGEMENT OF SUSPECTED POLIOMYELITIS—Arthur B. Light, M.D., Lawrenceville, N. J. 276
ENDOMETRIOSIS — Grace T. Newman, M.D., Montclair, N. J. 279
RUPTURE OF THE TIBIALIS TENDON—Paul Strassburger, M.D., Belleville, N. J. 281
LESIONS OF COLON AND RECTUM — Frank S. Forte, M.D., Newark, N. J. 283
ANTIHISTAMINIC TREATMENT OF DYSMENORRHEA — David B. Hoffman, M.D., Newark, N. J. 287
WARNING ABOUT LENS EXTRACTION IN EDENTULOUS PATIENTS — Howard P. Snyder, M.D., Elizabeth, N. J. 289

STATE ACTIVITIES— Page

National Science Foundation 266
Course in Gastroenterology 269
Accolade to Dr. Tarbell 275
Honor to Dr. Hyman Goldstein 278
New Merck Manual Available 282
Resolution on Death of Dr. Scott 290
The Physician and the Problem of Adoption. 290
Jefferson Celebrates 125th Anniversary 291
F.A.C.S. or Diplomate in Surgery? 292
Essex County Service for the Chronically Ill 295
Cerebral Palsy Course 295
South Jersey ENT Vacancy 296
Supplementary List of Members No. 3 296
Prize Award to Dr. Fernicola 298
Camp Physician Wanted 299

OBITUARIES 297

PUBLIC HEALTH NEWS 299

COUNTY SOCIETY REPORTS 300

WOMAN'S AUXILIARY 304

BOOK REVIEWS 306

TUBERCULOSIS ABSTRACTS 309

Roster of Officers, Advertising Page 3A

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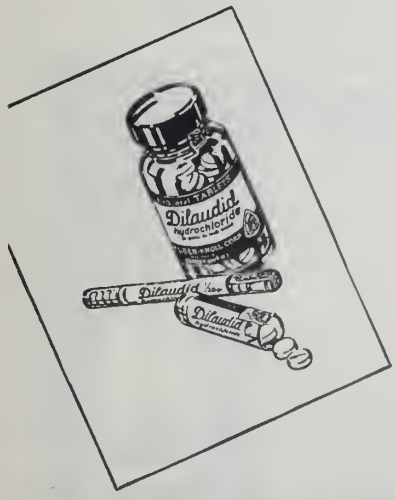

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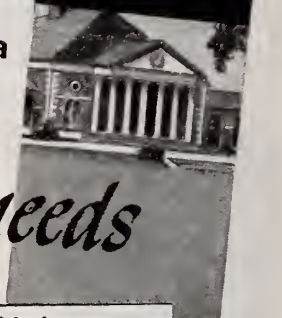

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There was a marked increase in the elimination of carbon dioxide in the expired air during the time the patient was in the mineral water bath. This increase did not occur in the plain water bath.

No evident variation in the oxygen consumption occurred with either bath.

The possible source of the excess carbon dioxide is discussed. The evidence supports the theory that this extra carbon dioxide is obtained by absorption of the carbon dioxide in the water through the skin and its subsequent elimination through the lungs.

It is, therefore, concluded that the results obtained in the treatment of patients with carbon dioxide mineral water baths depend, in part, at least, on the absorption of carbon dioxide through the skin and its subsequent influence on the circulation and nervous system which occurs in the process of its natural elimination by way of the blood stream and the lungs.

As printed in American Heart Journal, Vol. 29, No. 1, Pages 44-61, January, 1945.

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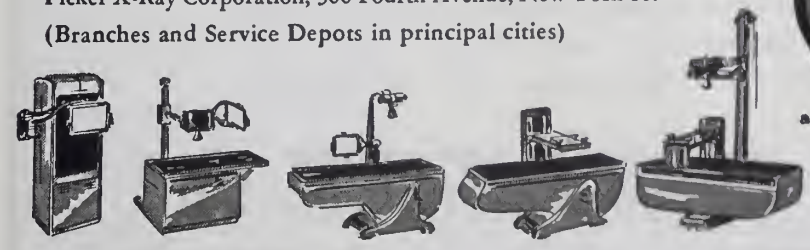

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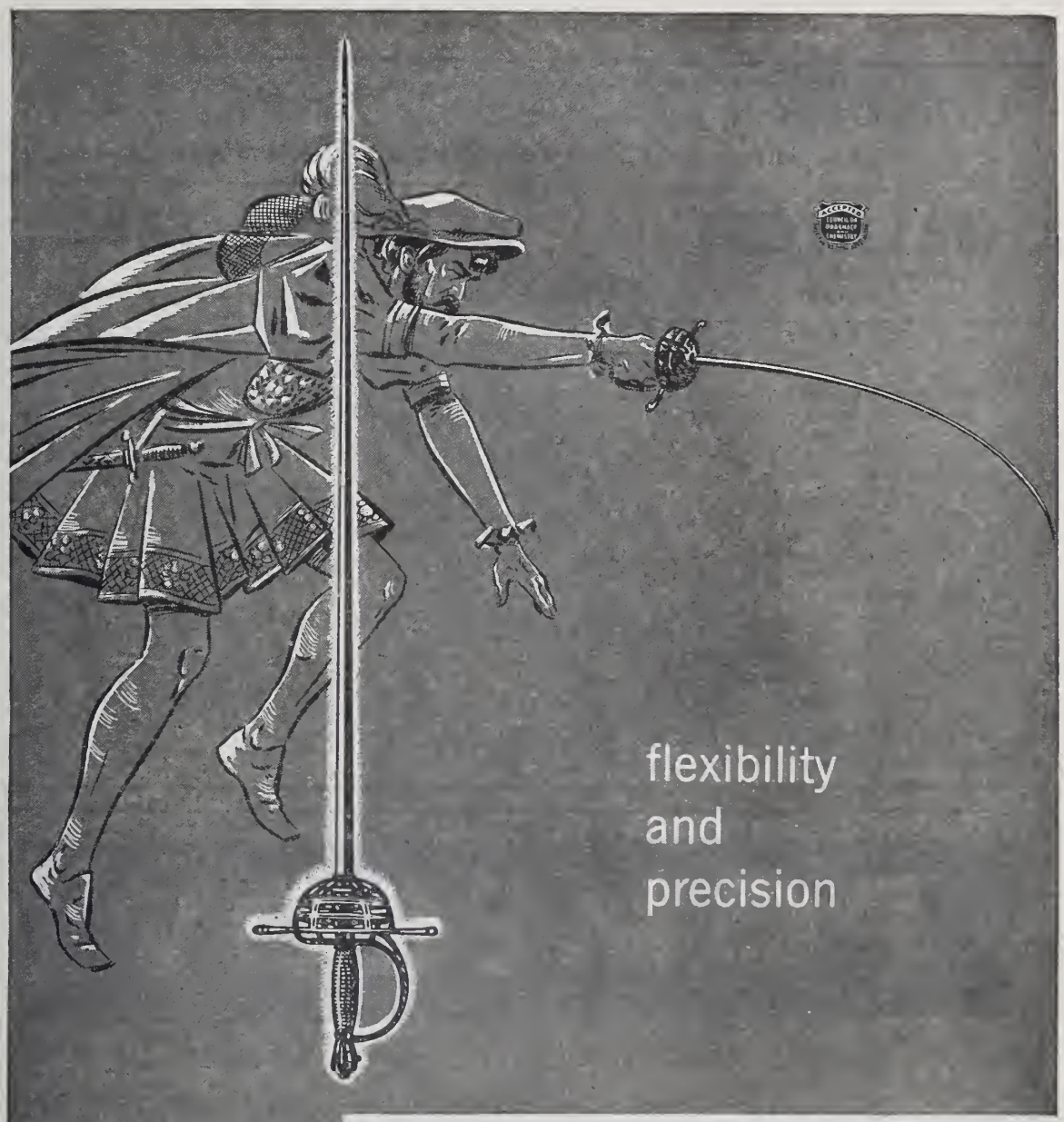

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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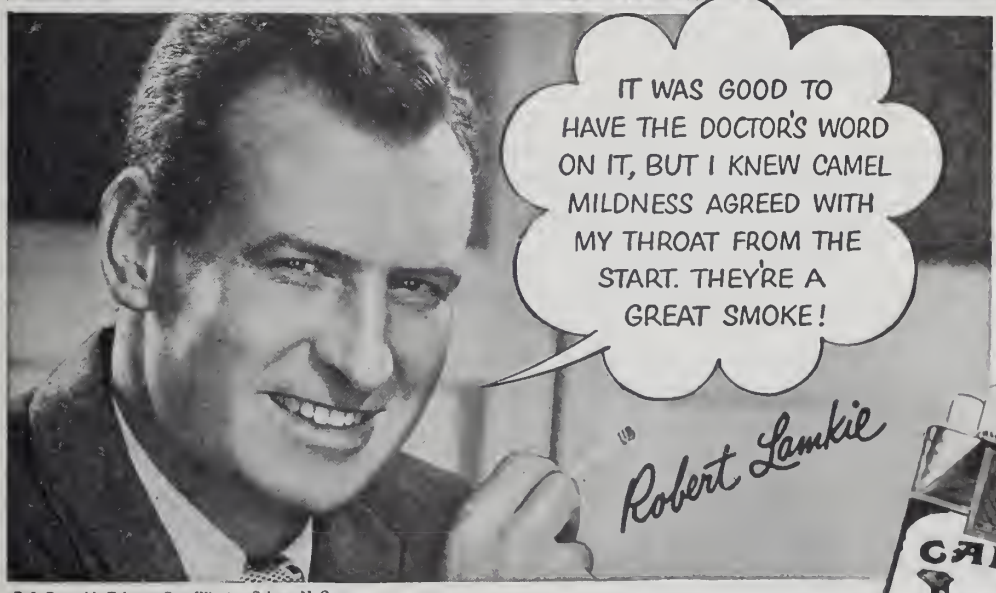

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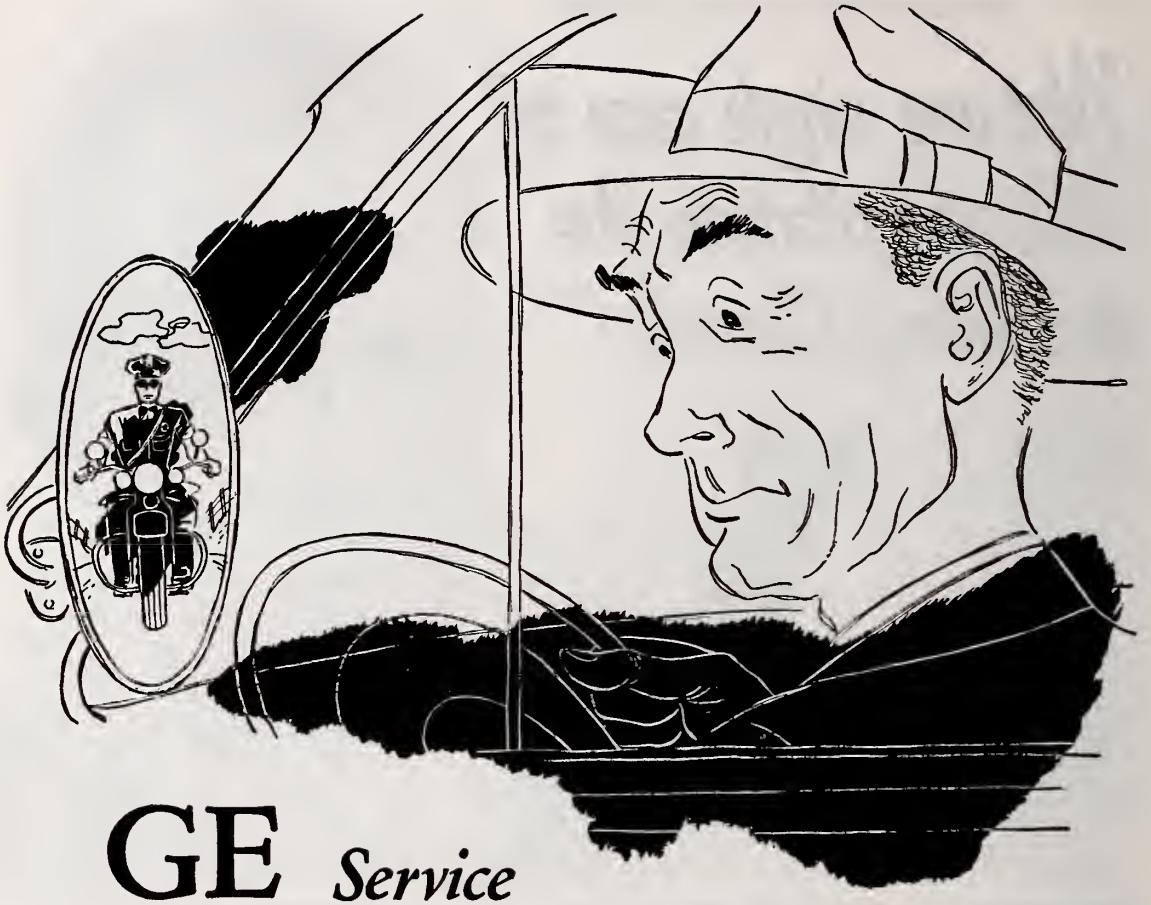

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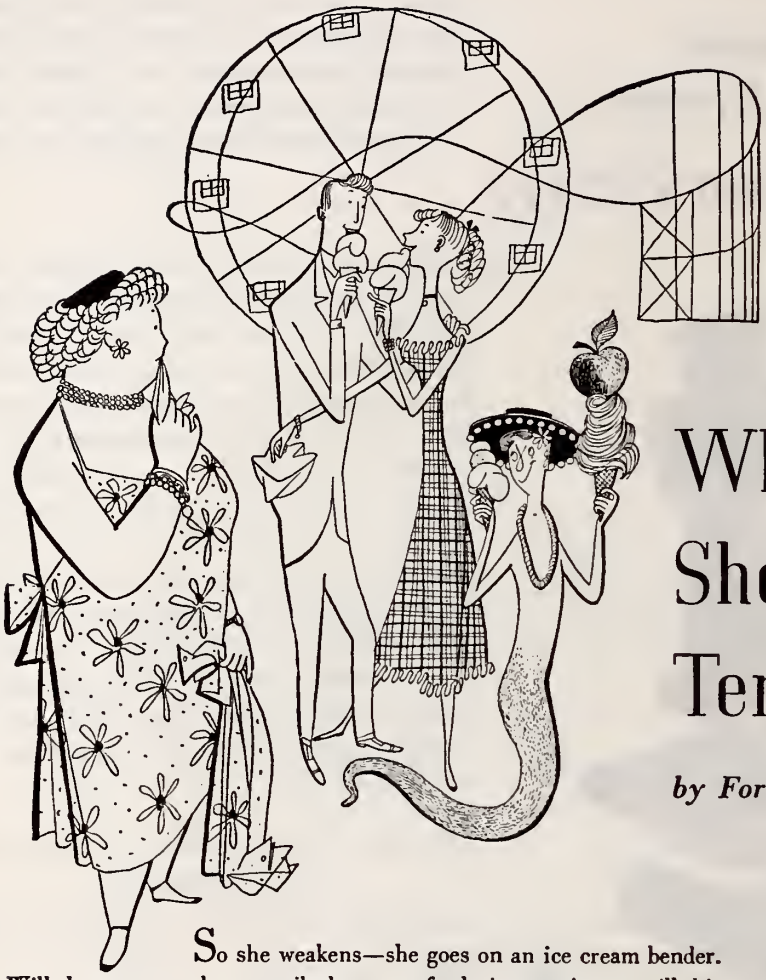

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Bibliography: 1. Loveless, M. H., and Dworin, M.: J. Am. M. Women's A. *4*:105, 1949. 2. Schiller, I. W., and Lowell, F. C.: New England J. Med. *240*:215, 1949.

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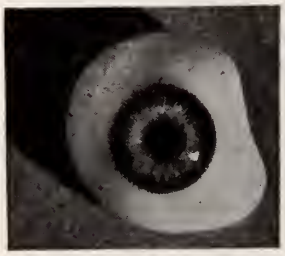

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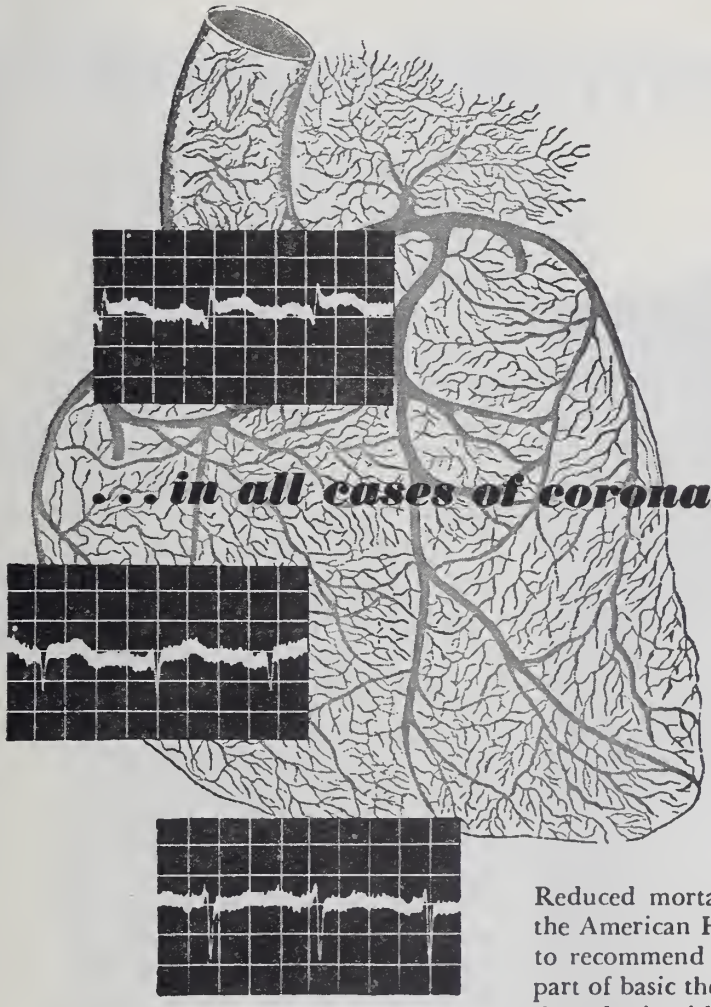

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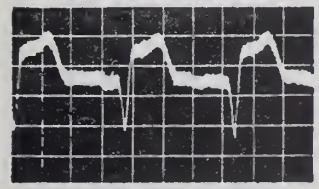

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1. Wright, et al: Am. Heart J. 36, 801 (Dec.) 1948.

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OUR NEW PRESIDENT

Medical society leadership these days implies more than clinical competence and organizational skill. The medical society has a unique role with reference to the community today, and we need leaders who have maintained strong community interests. In this respect, The Medical Society of New Jersey has been fortunate during the last few years. Our Presidents have, during that time, been active and articulate members of their communities as well as good doctors and competent organizers. This tradition is well-maintained by the selection of Dr. Aldrich C. Crowe of Ocean City as the 1950-51 President of The Medical Society of New Jersey.

Dr. Crowe has been active in service-organization, community and recreational activities in Cape May County.

He is a member of the Playground Commission of Ocean City. He is active in Legion and Kiwanis affairs, and devotes much of his professional time to the health and welfare of children. He comes to the presidency after a long apprenticeship in organizational activities. He served as national vice-chairman of the Section on Diseases of Children of the American Medical Association. On a state level, he first attracted notice when he was elected as Councilor of our state's fifth district, back in 1927. He labored long and effectively on the Board of Trustees of The Medical Society of New Jersey, having given fourteen years to that activity. He was secretary of that Board for many years, and more recently served as its chairman.

A native of Alabama, Dr. Crowe did his undergraduate work at the University of Chicago and the University of Alabama. He entered the Jefferson Medical College in 1917, and in 1921, he was one of the few chosen annually from local medical schools for internship at the Philadelphia General Hospital. On completing this service, he returned to his native state for residency experience in pediatrics at the Baptist Hospital in Birmingham. His medical school and internship days brought him into repeated, and favorable, contact with southern New Jersey and he elected to adopt our state in 1925. He was connected first with the Atlantic City Hospital, where he rapidly rose to be chief of pediatrics. He is now chief of the pediatric service at the Shore Memorial Hospital in Somers Point, and is on the pediatric staff of the Jefferson Hospital in Philadelphia. For more than fifteen years, Dr. Crowe has been a Fellow of the American College of Physicians. He is married and has two children, one of each gender.

For reasons well known to most of us, the 1950-51 period promises to be a year when a strong hand is needed at the helm of organized medicine in every state. The energetic leadership furnished by Dr. Norton has helped give New Jersey a spot-light position in the national medical picture. We can feel assured that with the installation of Dr. Crowe as President, this vigorous and firm leadership will continue.

PRESIDENT'S INAUGURAL ADDRESS

I am appreciative of the high honor conferred on me and my county by my election as President of The Medical Society of New Jersey. I am also very cognizant of the great responsibilities that go hand in hand with this office.

Our Society has been doubly honored this year on a national level:—first by the election of Dr. J. F. Norton as Vice-President of the American Medical Association; second by the selection of our own Mrs. David B. Allman as President of the Woman's Auxiliary to the A.M.A.

The citizens of this state have been very fortunate in the reelection of Governor Driscoll. He is a man who has never hesitated to take a definite stand opposing the welfare state and compulsory health insurance. Therefore, it is appropriate that we should take this opportunity to express our thanks to him and our approval of his actions.

Again New Jersey is quite fortunate in its Congressional representation. Most of our Congressmen are working along with Senators Smith and Hendrickson to fight the battle against compulsory health insurance. May I suggest that you read some of the statements these men have made on this vital subject? And may I also suggest that you, as individuals, give serious thought to this coming Novem-

ber election? It is a very crucial one as far as the medical profession is concerned.

Now for the coming year and some of the things I hope to see accomplished! First, last, and always there will be no easing in the fight against compulsory health insurance. The Woman's Auxiliary has been a tremendous factor in our educational program and if possible, I'd like to see this educational program expanded. Just as a mere suggestion, I pass on to the physicians that they try to emulate the efforts and accomplishments of the Woman's Auxiliary in this work.

Due to the compulsory health insurance battle, other vital activities of the Society have necessarily been overshadowed. Under this head comes the Welfare Committee. It is time now that this Committee and its important subcommittees take their proper places in the sun, so that you, as individual physicians, may know more of State Society activities. The junior officers and councilors will, from time to time, visit your county societies to discuss your problems and state problems. This will naturally result in a closer liaison between the state and county organizations. As your President, I hope to make each individual member of our Society feel that this Society is his own and to it he owes a responsibility.

Again thanks to you and my promise to you that the keystone of this next year will be consultation and cooperation.

Aldrich C. Crowe, M.D.

N. J. CANCER CRUSADE COMMENDED

Presentation of a 1950 "Cancer Crusade Citation" by the American Cancer Society to New Jersey, and particularly to the New Jersey Division of the Society, is a great tribute to the physicians of the state. The award is made in recognition of four years of progress in clinic activities. In making the presentation to Dr. Royal A. Schaaf, chairman of the executive committee of the Division, Dr. Charles S. Cameron, medical and scientific director of the Society, declared that the national group recognized the fine program organized under the direction of Dr. William O. Wuester, chairman of the Medical Advisory Committee of the Division.

When the program of cancer control was started three years ago there were only eleven tumor clinics operating in New Jersey's general hospitals. Today there are 51. Of these, 26 have received full approval of the American College of Surgeons and four have provisional approval. The remainder expect to receive approbation during the next survey.

The fine showing of these clinics has been made possible through financial aid extended by the New Jersey Division of the American Cancer Society. Equipment so necessary in the clinics has been provided on request to the Medical Committee and in addition the cost of nursing and clerical overhead has been underwritten by the Division.

The close cooperation between physicians and laymen in New Jersey has been the foundation of the program, which is proving so successful that many other divisions throughout the country are patterning their activities along the same lines. It is a true example of what can be accomplished when groups work together to a common end.

ORIGINAL ARTICLES

WHY MEDICAL ECONOMICS?

Frank G. Dickinson, Ph.D.,* Chicago, Illinois

During recent years there has been a highlighting of interest in medical economics. While there are many reasons for this shift of emphasis, three factors stand out. These are (1) technologic medical changes, (2) higher prices, and (3) medical progress.

TECHNOLOGIC MEDICAL CHANGES

Two excellent illustrations of how technologic changes in treatment have led to improved results plus increased costs are furnished by Dr. H. H. Shoulders, past president of the American Medical Association. Dr. Shoulders[1] says:

> "When appendicitis was treated largely by the administration of opium pills and the application of poultices to the abdomen, the cost of administering such treatment was low but the resulting mortality was high. When the physician acquired an understanding of the disease and perfected a technic for its proper treatment, the mortality from the disease went down to a low level but the cost of treatment went up. When diabetes was treated largely by diet and the administration of codeine, the cost of such treatment was low but the mortality was high. The diabetic patient lingered in discomfort for a relatively short while. But when the members of the profession acquired an understanding of the disease and developed a specific method for its treatment and management, diabetic patients were given an almost normal life expectancy in comfort and usefulness. Thus the problems in medical economics have been brought to the forefront."

On the other hand, some technologic improvements in therapy have actually reduced the cost of illness. Recently I heard a leading otologist say that the number of mastoid operations which he was currently performing averaged about two per month, whereas a decade and a half ago he was doing about 25 per month. He said: "The reason is simple; the general practitioner can administer sulfa and penicillin just as efficiently as my nurse." I make the observation, as a layman, that the "wonder drugs" have sharply diminished the economic value of this great surgeon's skill in performing mastoid operations. And although the economic impact upon him and his fellow specialists may create some hardships, I am sure that they and you and all America are grateful for these drugs.

Another example of decreasing cost is found in changes in the treatment of pneumonia. Last month I visited a physician in Nebraska. His charming wife gave me a practical lesson in medical economics. She told me that they had decided, years ago, to use for living purposes all of her husband's fees except those for delivering babies and treating pneumonia; they planned to save these two types of fees. The first of these two sources of savings almost dried up during the 1930's but boomed spectacularly with the increase in the number of births in the 1940's. On the other hand, in the old days, a pneumonia case meant three dozen visits, whereas now it means only three or four. So pneumonia and mastoid operations are, in a certain sense, contrary to the general trend of increases in the cost of medical care due to technologic medical changes. These are only a few examples among many of increasing and decreasing cost trends. The net balance of these changes, however, is tipped toward *increasing* cost. This has created a problem of medical economics.

HIGHER PRICES

Since 1933 there has been a sharp increase in the prices of all goods and services. The inflationary spiral started with a series of bank closings and with the devaluation of the dollar. During the past sixteen years, the American people have acquiesced in the doctrine of higher

* Dr. Dickinson is director of the Bureau of Medical Economic Research of the American Medical Association. This paper was read before the Essex County (N. J.) Medical Society on October 13, 1949.

1. Shoulders, H. H.: Journal of the American Medical Association, 134:703 (June 21, 1947).

prices as a remedy for real and fancied economic ills. In fact, they have almost come to worship a rising level of prices. In other times and places, inflation has turned out to be a false god. If we are to understand the economic highlights of this period, we must never call it a period of *high* prices. It is a period of *higher* prices.

The costs of medical care have, of course, risen during this inflationary period. A larger number of dollars is needed to meet the costs of medical care, particularly for a major illness. Medical care prices, however, have *not* risen as fast as the general cost of living. In fact, according to the United States Bureau of Labor Statistics,[2] the consumer's price index stood at 171 in 1948 whereas medical care items, which constitute a small portion of that general index, stood at 141. Without bothering you with all the details and the limitations of comparing a piece with a whole—in this case a piece of a price index with a whole price index—let me say for the practitioners of medicine in the United States that, in this period of rapidly rising prices of goods and services, the *American consumer has been able to purchase medical service at price levels which have risen only slightly more than half as fast as the general cost of living.*

Moreover, the entire outlay for medical care during the 1930's and 1940's has fluctuated narrowly around 4 per cent of the total family expenditures for all goods and services.[3] That is, the American people have chosen, year in and year out during the past two decades, to spend 96 per cent of their family budgets on items other than medical care. That isn't my decision, that isn't the decision of the Essex County Medical Society, that isn't the decision of the American Medical Association, that isn't the decision of anybody in Washington, D.C. It is the decision of *all the people.* They spent only 4 per cent of their money for medical care, not because they did not have more to spend, but because they thought they could get what they wanted most by spending 96 per cent of their money on items other than medical care.

How can an American family today be reasonably certain that its expenditures for medical care will fluctuate around 4 per cent of the family budget? Obviously, any one family must resort to insurance in order to normalize its medical care expenditures. Sixty-five million Americans have some kind of hospital insurance. Thirty-eight million have some kind of surgical insurance and fourteen million have some kind of medical insurance.[4] According to the report of the Hoover Commission,[5] some 24,000,000 people—about one-sixth of the nation—are now receiving some medical care from the federal government. I do not know how many are being provided with medical care by local and state governments.

The statement is often made that voluntary health insurance is a good idea but it does not go far enough in covering costs. Solely because of the wide variety of policies sold by insurance companies I shall confine my remarks to Blue Cross and Blue Shield types of voluntary plans which have fairly uniform provisions. The average family will be reimbursed by Blue Cross for a little more than 80 per cent of all of the family's expenditures for hospital care.[6] The average family is reimbursed by Blue Shield for between 50 and 60 per cent of the amounts paid for the services of physicians during the year.[6] The percentage for Blue Shield subscribers is much lower because patients are screened by physicians before they enter hospitals where medical care is covered by Blue Shield and the Blue Shield plans usually—and I think very wisely—exclude coverage of home and office calls. These calls, however, become part of the total bill for physicians' services incurred by Blue Shield subscribers. Presumably most of the other expenditures for physicians' services (which are not paid by Blue Shield) are dis-

2. Dickinson, Frank G.: Journal of the American Medical Association, 139:591 (February 26, 1949). Also reprinted in Bulletin No. 67, Bureau of Medical Economic Research of the American Medical Association, 1949.

3. Dickinson, Frank G.: Bulletin No. 66, Bureau of Medical Economic Research of the American Medical Association, 1948.

4. Data estimated by the Author by projection to July 1, 1949, from data as of December 31, 1948, reported in *A Survey of Accident and Health Coverage* published August 1949 by the Health Insurance Council. (page 5.)

5. The Report of The Commission on Organization of the Executive Branch of the Government: Reorganization of Federal Medical Activities. U. S. Government Printing Office. March 1949, (page 3).

6. Dickinson, Frank G.: Bulletin No. 71, Bureau of Medical Economic Research of the American Medical Association, 1949.

tributed over a period of time and are comparatively small in amount. You will note that I have used the term *average*. I did not say that every family was reimbursed to the extent of 80 per cent of its hospital expenditures and to the extent of 50 to 60 per cent of its expenditures for physicians' services. Low-income families are usually above, upper-income families usually below, these averages.

A family certificate for both Blue Cross and Blue Shield costs the price of a package of cigarets a day—or a bottle of beer or a gallon of gasoline. How many families cannot afford to pay the price of a pack of cigarets a day? *Voluntary prepayment of medical costs can solve, in large part, the problem of medical economics for the average family.*

MEDICAL PROGRESS

I have stated two causes for the problem of medical economics coming to the forefront in the practice of medicine — first, technologic medical changes and second, inflation. I now pass to the third and most important cause; namely, medical progress. Here is the record[7] of our health progress since 1900:

1. In 1900, 33 per cent of the people dying had lived at least 50 years; in 1949, 73 per cent.
2. In 1900, the older half of the people dying had lived 30 years or more; those dying in 1949 lived 66 years or more.
3. A baby born in 1900 was then destined to live 49 years; one born in 1949, at least 68 years.
4. Since 1900 the population age 65 and over has quadrupled, whereas the whole population has only doubled.
5. The *lowest* state maternal mortality rate in 1933 was 4.3 whereas the *highest* state maternal mortality rate in 1948 was 2.7.

Point 1 speaks eloquently for itself. In 1900, 33 per cent of the people dying had lived at least 50 years; in 1949, 73 per cent of the people dying had lived at least 50 years.

In 1900 the older half of the people dying had lived 30 years or more; the older half of those dying in 1949 had lived 66 years or more. This second point is reflected in the changing tenor of funeral sermons. Where once a man was old at 30, now the funeral sermon for a 30-year old man is concerned with unfulfilled hopes, and the lost opportunity to serve his family and community. The death of a 66-year old man todays calls forth praise for work he has completed, and admiration for his wise counsel; only the leisurely retired years were denied him.

Point 3 is remarkable because it reflects such an extraordinary rate of medical progress. The average baby born in 1900 was destined to live 49 years; a baby born today has a life expectancy of 68 years. The patrician of classical Rome died at the average age of 25. Although we usually think that Jesus died a young man at age 32, in reality He was old for His time. Even as late as 1700, in Germany, average age at death[8] was 33. Raising life expectancy at birth to 49 by the year 1900 was then hailed as a great accomplishment. The half-century from 1900 to the present, however, saw a spectacular increase in life expectancy at birth (from 49 to 68). Surely this entitles us to call the last five decades, "man's greatest half century".

Point 4 reemphasizes the problems of older people. Since 1900 the population age 65 and over has quadrupled, whereas the whole population has only doubled. While part of our aging population must be attributed to a declining birth rate during the 1930's, medical progress has succeeded in saving so many younger persons from death that more persons than ever are living into old age.

Point 5 tells the most dramatic story of medical progress in recent years. Since 1933 the United States has made tremendous progress, with the maternal mortality rate declining from 6.2 to 1.2 in fifteen years; in 1947 the rates for whites and non-whites were 4.5 (5.6-1.1) and 6.4 (9.7-3.3) lower than in 1933. Many other nations are

7. Points 1, 2 and 4 have been due largely but not entirely to health progress. A population could also age because of: (a) long-term decline in birth rate (b) steady increase in the number of older immigrants, or (c) considerable decrease in the number of younger immigrants. Factors *a* and *c* have, to some extent, speeded up the process of aging. However, actual longevity has also increased since 1900.

Who can say what would have happened to the birth rate if as many babies had to be born in 1949 to produce a thousand teen-agers or adults as were required in 1900? I suspect that one major reason for the decline in birth rate has been health progress which "economizes" on the number of babies needed to reproduce the adult population.

8. Average age at death was the same as life expectancy during this period characterized by a relatively unchanging death rate. In a period of rapid health progress, however, the two figures are different because, by the time the baby has grown up, new medical progress has already lifted his contemplated life expectancy ceiling. In periods of progress, therefore, life expectancy at birth is higher than the number of years lived by persons dying in that year.

also experiencing a substantial fall in maternal mortality rates. Thus, among white women in New Zealand, the 1947 rate was only 1.1 maternal deaths per thousand live births. In the United States the spread between the highest and lowest state rates decreased from 7.2 (11.5 to 4.3) in 1933 to 2.3 (2.7 to 0.4) in 1948. More important than the decline for the whole nation is the fact that the highest state rate in 1948 was 2.7, which was less than two-thirds of the rate (4.3) for the best state in 1933. To the extent that this one vital statistic can be considered an index of health, the charge that rapid improvement in health has been limited to the wealthier sections of the country is clearly and emphatically refuted.

CRADLE TO THE GRAVE

Our population has aged largely, but not entirely, because of what you physicians and your predecessors have been doing. Some people, in a discussion of compulsory sickness insurance, volunteer the thought that "the doctors have brought it on themselves". I think they have. Doctors have given people longer life. There are rapidly increasing numbers of old people in the population who have completed their working period of life and to whom the promise of tax-financed medical care makes an understandably strong appeal. What I am trying to say is that the principal reason for the ascendancy of problems of medical economics is medical progress itself.

Nobody seriously advocated "cradle to the grave" schemes in 1900 because most of the people were close to the cradle; now most of the people are relatively far from their cradle days. Let me give you my own definition of "cradle to the grave": It is a scheme whereby those close to the grave would fasten themselves on the paychecks of those closer to the cradle and ride piggyback toward the grave. When I first dictated that definition to my secretary, the last phrase came back "and ride piggybank to the grave". Perhaps I should have let it stand as she had it.

I think that many of the problems in society today which disturb us so greatly—the conditions that cry out for some solution—are traceable to the aging of our population. The road from birth to death for the average man has lengthened rapidly during this first half of the twentieth century. But there are many eddies in the stream of social progress, and one of these we face today. It is the opportunity for those of us who have lived half a century or more to thoughtlessly exploit the youth of the nation.

The greatest problem of social morality of our times is to play fair with youth. This is precisely what no scheme of compulsory sickness insurance now under consideration does. We need, concomitant with medical progress, a change in social ethics to keep pace with medical progress. But we must not succumb to the low standard of social morality involved in the concept of "cradle to the grave". When you and I attained our majority, we could look forward to a lifetime of working, earning and saving. Our children can look forward only to a lifetime of working, earning and paying taxes. I, as a member of an older generation, am ashamed of the lot to which we have condemned our youth, and I hope that the present trend toward the doctrine of individual irresponsibility and the exploitation of youth can be stopped and that we can raise our standards of social morality.

THE DILEMMA FOR PHYSICIANS—AND PREACHERS

Allow me to interpret the significance of medical progress—aided by better housing, better food and better sanitation—to you, the members of the Essex County Medical Society. It is the disturbing premise of the practice of medicine that the doctor cannot win. When he saves a woman in childbirth he merely adds one more name to the list of potential candidates for cancer. When he saves a young man from pneumonia he merely adds one more name to the list of potential candidates for fatal heart attacks. The doctor can change only the age and cause of death. Ironically, the increase in the number of people dying from heart and cancer is a measure of past medical progress.

The preacher and the physician face the same dilemma: longer life and more old people. The fear of death is diminishing for young people; only the threat of a fatal accident seems

real to them. In fact, I have shown elsewhere[9] that fatal accidents represent the number one death hazard of the working people of this country. But young people don't go to church much nowadays. They did when you and I were young. Now they don't seem to feel the need of it. Although death is closer to the older people in any century, the fear of death diminishes with age. Yet older people seek and need the spiritual food of the church. The preacher today faces a congregation of older men and women. (With so many older people in the congregation he seems relatively young.) At the same time that he must work harder to interest young people in the church, he must minister to the aged and infirm who feel the need for his help. Medical progress has made "cradle to the grave" schemes more popular as the population ages, and it has also brought more old (and fewer young) people to the church. Thus, medical progress has created a dilemma for the preacher as well as the physician.

Perhaps this review of health progress, and this discussion of what I deem to be the three basic causes for the urgency attached to the subject of medical economics, may give some of you the impression that I think the doctor's task has been done too well. On the contrary, I believe firmly that the quest for better health and longer life can never end, but that so long as pain comes too often and death comes too soon, medical care will remain inadequate. There is no adequate medical care for the family of a dying person. Medical care can only go on to provide more and better years of active life to more and more people.

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THE NATIONAL SCIENCE FOUNDATION

Under Public Law 507 (May 1950) a National Science Foundation was created. The JOURNAL has received a number of requests for further information about the scope and operations of this Foundation, and the following information is accordingly published.

The Foundation has the mission of "promoting basic research in the sciences". This includes medical science. It will do this primarily by initiating, supporting and registering research projects. It is authorized to make grants and loans, to award scholarships, to act as a clearing house of information, to correlate research and to take over the present Roster of Scientific and Specialized Personnel. The Foundation will not actually operate any laboratories, but it may furnish space, equipment, personnel or funds to existing laboratories. The policy-making body will be a Board of 24 "persons eminent in the basic sciences" named by the President of the United States. The administrative head of the Foundation will be a full-time Director appointed by the President, after recommendation by the Board, and with the approval of the Senate. Technical and professional personnel of the Foundation may be appointed and compensated without reference to Civil Service laws.

9. Dickinson, Frank G., and Welker, Everett L.: Bulletin 64, Bureau of Medical Economic Research of the American Medical Association, 1948.

NICOTINIC ALCOHOL TARTRATE (RONIACOL TARTRATE*) IN THE TREATMENT OF PERIPHERAL VASCULAR DISEASE

REPORT OF THREE CASES[1]

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WALTER REDISCH,[3] M.D., New York, N. Y.

The physiology and pathology of peripheral blood flow and their clinical implications represent a field upon which attention has been focused only recently. One reason for such increased interest might be recent awareness of the fact that (aside from the heart) peripheral circulation calls for specific studies and considerations which are not covered by the principles governing the action of the central pump.

The main task of peripheral blood flow is to carry oxygen and nourishment to the tissues, to permit for metabolic exchange to and from the tissues through the capillary wall, and to carry away waste products. Any disturbance in peripheral blood flow results in impairment of these functions in their entirety or in part. The general concept of "impaired peripheral circulation" gains justification, if understood in this sense. The etiology, type and localization of the disease process (as well as the state of other systems) will make for a varied clinical symptomatology.

Any attempt at restoration of "impaired peripheral circulation" will, in most instances, call for measures designed to increase primary circulation and to facilitate the development of secondary circulation. Vasodilators are thought to be of value in this direction. The use of these drugs is still in the experimental stage. This might sound surprising in view of the many clinical studies with vasodilators reported within the past few years. However, critical evaluation of many of these papers reveals that the evidence presented is often not too impressive and that at times the conclusions drawn are unwarranted. The methods for appraising results, as for instance, the determination of changes in surface temperature, are frequently employed without proper care and without adequate basic approach. At present, therefore, any clinical study concerning "vasodilators" must be taken with a grain of salt until sufficient experimental evidence is available to delineate clearly where the action of different "vasodilator" drugs takes place; what the mechanism of such action is; and, what significance the different measurements employed have as indicators of the rate of blood flow.

It is hoped that such information will be furnished before too long. Until then, the discussion of peripheral vascular disorders and reports concerning the successful management of such disorders, should be confined to comments based on diligent and careful clinical observation.

As an example of such an approach, we are reporting in this paper three cases which present somewhat unusual types of impairment of peripheral circulation; they were managed by use of one of the newer vasodilators—nicotinic alcohol*—in which we have been interested because there are indications that this preparation may perhaps combine two types of vasodilator action: (1) that following the administration of different alcohols and (2) that elicited by nicotinic acid. Experiments suggesting this two-fold action will be described elsewhere in due time; their discussion is not within the scope of this purely clinical report.

CASE ONE

A 60 year old white male, retired naval Chief Petty Officer, had had for the past five years intermittent claudication after walking a few blocks

* Nicotinic alcohol tartrate, under its registered tradename of Roniacol Tartrate, was generously supplied through the courtesy of Dr. Leo Pirk of Hoffmann-LaRoche, Inc. Nutley, N. J.

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and, in cold weather, numbness of hands and feet. Three months ago, rather suddenly, ulcers developed on both hands. The lesions caused severe pain which increased progressively. Treatment consisted of "salves and pills". Physical examination on September 20, revealed: lungs and heart were within normal limits. Blood pressure was 130/88. The accessible arteries were thickened and beaded; both hands were cyanotic and the right radial pulse was absent. Severe trophic changes were present on both hands, but were more marked on the right. The second to fifth finger on the right, and the second and third finger on the left hand were tapering. The skin on all end-phalanges was shiny and atrophic. Deep ulcerations were present on the end phalanges of the second, third and fifth fingers on the right and the second and third fingers on the left hand. These ulcerations were covered with tenacious thick semi-dry crusts. Both hands showed 3-plus blanching on elevation and 4-plus rubor on dependency. The feet which were cyanotic and slightly puffy in appearance showed 4-plus pallor on elevation; dependency was attended by deep cyanosis which did not permit an evaluation of the degree of rubor. Pulsation of both dorsalis pedis arteries was palpable but not that of the posterior tibial arteries. No ulcerations were noted on the feet. Blood sugar was 96 milligrams per cent; blood urea nitrogen 12.8; blood cholesterol 152. The electrocardiogram showed left axis deviation and signs of coronary insufficiency. Erythrocyte count: 4,100,000; leukocyte count: 7150; hemoglobin: 90 per cent. The differential white blood count was as follows: neutrophils: 68; lymphocytes: 28; monocytes: 2; eosinophils: 2. The sedimentation rate was 13 in one hour. He showed early arteriosclerotic changes in the retina. X-ray revealed calcification of blood vessels in both lower extremities.

Impression: Generalized arteriosclerosis with particular involvement of small-caliber peripheral vessels and occlusion of the right radial artery.

Treatment was initiated on September 21, and consisted of a vascular routine[4] and 100 milligrams of Roniacol Tartrate* three times a day. Seven days later patient was able to walk six blocks. The ulcerations were drying up very fast. By October 20, there was considerable improvement. The cyanosis was less pronounced, and the ulcerations of the fingers were dry. The radial pulse was felt faintly. On November 21, there was continued improvement. The radial pulse was palpable on the right hand and the ulcerations were clearing. By December 12, all ulcers were completely healed. There were some scabs left on the right middle finger only. The patient is continuing on same treatment.

CASE TWO

A 31 year old white male, had had an injury to the left hand in 1938. The trauma was not followed by any disability after a secondary infection had healed. He had an attack of acute rheumatic fever in 1943 with swelling of the left knee followed two months later by involvement of the left hand, elbow and shoulder. Incapacity and swelling of left arm and hand have been present ever since. Repeated clinical and x-ray examination of chest and spine revealed no abnormalities. X-ray of left hand and wrist in October 1948 was reported to show "narrowing of joint spaces". Patient was first seen by us on October 17, 1948. Physical examination was negative except for the following: The left hand was swollen, very tender, pale and cyanotic. There was extreme pallor on elevation of the arm; a Dupuytren's contracture kept all the fingers except the thumb in complete flexion. Electrocardiograms (repeated on several visits) showed right bundle branch block. A diagnosis of arteriospastic disease of the left upper extremity (shoulder-hand syndrome) was made. Patient was hospitalized at the Bronx VA Hospital, where the diagnosis was confirmed, but no therapy instituted. He returned to the Newark VA Clinic and was placed on a vascular routine[4] for two months. This did not help. In the middle of February he was given 300 milligrams of Roniacol Tartrate* per day to be taken orally in divided doses. On his next visit (March 9) he volunteered the information that there was less pain, less swelling, and that he was able to move his arm better and to open his fist somewhat. This was corroborated on examination. There was steadily continuing improvement during the following weeks. On June 15, the hand was straightened out to about 50 per cent with considerably less pain; the swelling was down to a minimum and the fingers were freely movable; but the left hand was still colder than the right, slightly cyanotic and hyperhidrotic. When treatment with Roniacol Tartrate* was discontinued, all previous symptoms and signs, including swelling, increased contracture and increased pain returned within ten days.

On July 26, Roniacol Tartrate* was reinstituted. We gave 600 milligrams per day for several months. On December 19, the patient was symptom free, showed no swelling, his hand was almost straight, the fingers freely movable; the hand was hardly cyanotic and still showed some increased perspiration. The drug was again discontinued on that day. Within two weeks his signs and symptoms started to reappear.

CASE THREE

A 27 year old medical student had had a history of first superficial, then deep thrombophlebitis in the left leg two years ago. There had been two episodes of pulmonary infarction in May and again in June of 1949. Treatment with Dicumarol[5] was then initiated and ligation of the vena cava inferior was performed on July 22, 1949. A diagnosis of Buerger's disease was made. Therapy consisted of Tolserol[6] and 100 milligrams of Priscoline[7] per day orally. The patient has had no relief from excruciating pain in the left leg from the knee down. He has not been able to use his left lower

4. This routine is described by the author in a previous paper: Redisch, Walter, Journal of The Medical Society of New Jersey, 46:368 (1949).
5. Dicumarol is the registered trade-mark of the Wisconsin Research Foundation.
6. Tolserol is the E. R. Squibb registered trade-mark for their brand of ortho-toloxy-propanediol.
7. Priscoline, formerly designated as Priscol, is the Ciba Pharmaceutical Products Inc., registered trade-mark for their brand of benzazoline hydrochloride.

extremity at all since the operation. Three nerve blocks had been done without significant results. When first seen by us on August 25, 1949, he walked on crutches; there was a foot drop on the left side. The left lower extremity was held in half bent position and could be straightened out only with severe pain. The left foot was distinctly colder than the right. Pulsation of the dorsalis pedis artery on the left side was not felt, but was normal on the right side; the pulsation of both posterior tibial arteries was normal. Oscillometric readings were minimal on the left and normal on the right. There was an area of hyperesthesia over the lateral part of the dorsum of the left foot. Edema was absent. The left foot was paler than the right. Both feet showed marked rubor on dependency. Color return on the left was definitely delayed (over one minute); there was a well-healed abdominal scar (after ligation of the vena cava inferior). A diagnosis of reflex distrophy of the left lower extremity was made. This was confirmed by Steinbrocker[8] who was among those who described this type of disorder. The patient was given 600 milligrams of Roniacol Tartrate* per day by mouth. He started to report improvement after about two weeks. Since early October 1949 (about seven weeks after initiation of treatment) he has not been using any crutches. Examination on October 11, bears out the patient's report that the left leg is now much warmer than the right. Oscillometric readings were normal on both sides. The pulses on the left side were bounding. There was no swelling and no more postural pallor. The venous return time, which was 8 minutes on the right and 23 minutes on the left, on August 25, 1949, was 8 on the right and 15 on the left on October 11. The patient had only little pain on fatigue, no complaints except for some swelling on the left leg after having been on his feet all day. He was taken off Roniacol Tartrate* by the middle of November and is being studied at the New York University Research Service at Goldwater Memorial Hospital as an ambulatory patient. At the time of this writing—about two months after patient had been taken off the drug—he has just started to complain about increased pain in the left leg.

DISCUSSION

Evaluation of the therapeutic results in chronic peripheral vascular disorders is difficult as it is in all chronic cases. These cases had the following in common: they had all shown no improvement for varying periods of time (three months; "several" years; and two months, respectively) and they all improved rapidly on the regimen outlined.

It is possible that patient number 3 might have improved as he did without the administration of nicotinic alcohol tartrate.* But the fact that he was able to dispose of his crutches three weeks after initiation of treatment with nicotinic alcohol renders this unlikely.

Patient number 2 presents an even more impressive response as far as the time element is concerned; while, for six years, there was no benefit at all under various types of treatment, he improved within six weeks on nicotinic alcohol tartrate* and this improvement has been progressing steadily. Discontinuation of the drug caused aggravation of symptoms on two occasions within about ten days; a trial on placebo has not yet been made for technical reasons. Of course, a psychogenic factor must always be considered in vaso-spastic disorders.

Patient number 1 showed such rapid clinical improvement on nicotinic alcohol tartrate* after three months of general care had failed to produce any improvement, that it is difficult to dissociate this improvement from the use of the drug.

SUMMARY

The difficulties in evaluating therapeutic effects in peripheral vascular disorders are briefly outlined.

Three cases of rather unusual peripheral vascular disorders are reported in whom administration of Roniacol Tartrate* proved highly beneficial.

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8. Steinbrocker, Otto, *et al.* Annals of Internal Medicine, 20:21 (1948).

REHABILITATION IN ACTION

A CASE REPORT *

James F. Gleason, M.D., Atlantic City, N. J.

Rehabilitation, in the fullest sense of the word, is a major challenge to American medicine today. World War II served to focus our attention on the restoration of the neurologic, orthopedic and psychiatric military casualty, but many chronic invalids among our civilian population have suffered from years of comparative medical neglect. It is with the effective rehabilitation of one of these civilians that this paper concerns itself.

A 36 year old white male, was referred to the Ventnor Clinic by the New Jersey State Rehabilitation Commission on February 2, 1949, for diagnostic study and for appraisal of his rehabilitation potential. This patient had suffered from headaches and fainting spells since a head injury in 1933.

The family history was negative for epilepsy or other nervous and mental diseases. He had been married seven years and was the father of two children. His habits were moderate. His past medical history was uneventful.

He had been well until the winter of 1933 when a truck, in which he was riding, plummeted down the side of a mountain. He sustained fractures of the skull and thoracic spine, and minor injuries of the left hand. He was unconscious, or at least "out of contact", for many hours. "I didn't come to until the next day." He was admitted to a large hospital in another state where two skull operations were performed, the first a few months after the injury. Neither procedure involved the removal of bone.

Following this surgery and about six months after his injury, he experienced the first of many "black-out spells". These were essentially acute confusional episodes resulting in many brief hospitalizations. One year after his injury, he had a craniotomy in a hospital in Philadelphia. For the first time, bone was removed; a large parietal defect resulted.

The headaches which had followed his injury increased in severity and frequency after this operation. These were consistently left parietal in origin with left orbital and frontal radiation. They were pounding or throbbing headaches aggravated by cold or stormy weather, by sudden position change, and by increased fluid intake. In 1940, their frequency increased; by 1948 they occurred almost daily, with scant relief from huge doses of self-prescribed proprietary anodynes. In the patient's words: "My head builds up as though it is ready to explode, and I develop a splitting headache; I must lie down and take aspirin".

In 1940, he experienced (for the first time) grand mal seizures, at the rate of two to five a year, associated with status epilepticus and post-epileptic automatism, often requiring hospitalization; these usually followed increases in fluid intake, particularly small amounts of alcohol. The only aurae were splitting, crescendo-like headaches with "spots in front of my eyes".

He had become extremely conscious of his skull defect, with pain at this site induced by coughing, laughing or straining. The association of pain, headaches and major seizures had made it impossible for him to pursue his occupation as a housepainter.

During 1948, he had taken as many as twenty aspirin and twelve teaspoonsful of Bromo-Seltzer a day. He had a complete intolerance to alcohol, and had developed definite suicidal trends, attributed to headaches and financial insecurity. His pain prevented him from sleeping, during the long night hours he would try to devise a means of death by violence which would still permit his wife to collect his double indemnity insurance. He had manifested according to his wife, a marked personality change, characterized by irritability, impatience, insomnia, and apathy.

General physical examination was non-informatory except for an elliptical left parietal skull defect, 7½ by 9 centimeters in the longest transverse and longitudinal diameters. This was covered by well-healed scalp overlying firm scar tissue, nonfluctuant, but with slight pulsation. There was moderate bulging of the contents when the head was lowered. The edges and center of the defect were tender to palpation; such palpation also produced intermittent shock-like sensations in the left eye. Blood pressure was 130/80.

Neurologic examination revealed minor changes in the deep tendon reflexes. The left biceps and knee jerks were slightly increased and the left triceps jerk decreased. There were bilaterally positive "finger-stretch" responses in the upper limbs, more active on the left. The remainder of the examination was within normal limits.

Psychiatric examination indicated a considerable degree of psychomotor retardation, with poor attention and interest. He appeared depressed, apathetic, sluggish, flat and listless. He was completely preoccupied with his symptoms and their impact on his personal and financial life. He acknowledged suicidal trends. Orientation was superficially impaired. Recall and retention were only fair. General knowledge was not in keeping with opportunity. Recent memory was impaired. Counting, calculation, reading and writing were satisfactory.

Routine blood and urine studies were within normal limits. Glucose tolerance test was abnormal:

* Presented at the Ventnor Clinic Staff Meeting, Atlantic City, N. J., February 8, 1950.

Fasting	81 mgm. %
½ hour	88 mgm. %
1 hour	95 mgm. %
2 hours	105 mgm. %
3 hours	81 mgm. %

X-ray of the skull showed a large defect measuring 7 centimeters in the sagittal and 8 in the coronal diameter, extending from the region of the coronal suture to a point about 3 centimeters rostral to the lambdoid suture. Margins of the defect were smooth and the bone appeared healthy. X-ray studies of the thoracic spine showed old fractures of T8 to T11 with marked secondary arthritis change.

An electroencephalogram on February 12, 1949, was interpreted by the neurologic consultant[1] as follows: "Markedly abnormal record with asymmetrical irregular delta activity and superimposed bursts of multiple spikes localized to the left motor and inferior motor-parietal region (over the superior-anterior quadrant of the skull defect). This record is consistent with localized brain damage and an irritative focus underlying the left motor and left motor-parietal electrodes. The multiple spike discharges are rather typical of post-traumatic epileptic states resulting from meningocerebral cicatrices." For this reason the consultant recommended cranioplasty preceded by routine anticonvulsant therapy.

At this point, through the determined and effective efforts of a member of the Rehabilitation Commission[2] the patient was admitted to the neurosurgical service of the Jefferson Medical College Hospital where, on April 28, 1949, a *pneumoencephalogram* showed slight left ventricular presumably due to traction at the site of the injury. An electroencephalogram showed a generalized paroxysmal dysrhythmia.

On May 2, 1949, *cranioplasty* was done by Dr. William H. Whitely. The dura was found to be four times normal thickness. Over the left motor cortex there were many vascular meningo-cortical adhesions. These were not disturbed. The brain was normal except for slight pallor. A bony shelf was fashioned in the perimeter of the skull defect and a molded lucite plate, contoured to fit the bony opening was wired in place.

The immediate post-operative course was uneventful. Since his operation, he has had neither headache nor major seizure. He has become alert and cheerful. In September 1949, he returned to work as a painter at a salary of $72 a week. In January 1950, he successfully passed a medical examination for employment by another firm. He now requires neither anticonvulsants nor analgesics. The stigmata of the organic mental syndrome present before operation have disappeared. His neurologic examination is within normal limits. A post-operative electroencephalogram has not been done. In most patients of this type, despite complete symptom relief after cranioplasty with plating, the electroencephalogram is unchanged.[3]

The problems of post-traumatic epilepsy and the syndrome of the trephine have been discussed at great length elsewhere.[4] We do not propose to discuss these clinical entities but wish to emphasize instead the practical application of the broad principles of rehabilitation illustrated by this case history.

It is significant that a man, invalided and incapacitated for many years by headaches, acute confusional episodes, grand mal epilepsy, progressive deterioration of personality, suicidal tendencies, and an organic mental syndrome, should be restored to useful function and to a state of financial responsibility. It is even more significant that this restoration should result from the enthusiastic cooperation of private medicine and a State Commission.

A case of this type demonstrates how effectively the various medical specialties may cooperate. Herein, the combined energies of the internist, the neurologist and the neurosurgeon blended to achieve the best possible result for the patient. The prospects for rehabilitation of any patient are brightest when the resources of the general medical man and of the more limited specialties are pooled.

Eppinger[5] has popularized the concept of reversible heart disease. Krause[6] has broadened this concept: he suggests that we think first in any diagnostic problem of the reversible conditions for there we can be most helpful. Our patient endured sixteen long years before the reversibility of his disease was established. All of us, then, in any given clinical problem, might do well to ask ourselves: "Is this disease reversible?" Whenever the answer is "yes", we should leave no stone unturned to effect this reversal. This truly is rehabilitation in action.

SUMMARY

A case of post-traumatic epilepsy associated with the syndrome of the trephine has been presented, in which, after a one year follow-up apparent rehabilitation has resulted. Comments are made concerning the desirability of cooperation between private medicine and state bureaus, and among the various medical specialties. The concept of reversible disease has been emphasized.

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The citations appear in the author's reprints

SARCOID SPLEEN WITH THROMBOCYTOPENIC PURPURA

Meyer Notkin, M.D.,[1] Frederick M. Offenkrantz, M.D.,[2] and
Anthony Abramo, M.D.,[3] Paterson, N. J.

Although sarcoidosis of the spleen is not too uncommon, its association with thrombocytopenic purpura is unusual. A search through the literature reveals very few published cases.

Bernstein[4] in 1938 reported a case of systemic sarcoidosis involving the mucous membrane of the larynx, pharynx, and soft palate which was also associated with a thrombocytopenic purpura. Norland *et al.*,[5] in 1946 described a case of pregnancy complicated by thrombocytopenic purpura and sarcoid spleen which was diagnosed following splenectomy. The operation was performed in the fifth month of pregnancy because of dangerous bleeding tendencies and serious complications that would be encountered at term. All the bleeding tendencies ceased immediately following splenectomy and the case went to term followed by a normal spontaneous delivery.

For years in the past, men in various specialties saw a disease syndrome that had been peculiar to their specialty. It was known as *uveoparotid fever* to the ophthalmologist, *lupus pernio* to the dermatologist, and the roentgenologist described it as an atypical form of *pulmonary miliary tuberculosis.* When first described by Hutchinson[6] in 1875, however, it was thought to be a skin disease. In 1889, Besnier[7] described similar lesions that involved the face, ears and fingers, and called it lupus pernio. In 1899 Boeck[8] made a histologic study of the lesions, and noted that the lymph nodes and mucous membranes may also be involved. He applied the term "Sarcoids of the skin" to this affection and believed it to be due to an infiltration of the skin by a leukemoid tissue. For a number of years Boeck's sarcoid was regarded as a dermatologic condition only. Fifteen years later Schaumann[9] demonstrated that the internal organs as well as the skin, mucous membranes, bones and lungs may be involved, thereby revealing sarcoidosis to be a systemic disease. Since this time it has been shown that any organ of the body may be involved. In 1909 Heerfordt,[10] described the syndrome consisting of ocular lesions and parotitis with bilateral facial paralysis. The relationship between the uveoparotid syndrome and other manifestations of the sarcoidosis was recognized by Pautrier[11] in 1938. Attention was first directed to bone changes in 1919 by Jungling.[12]

The etiology of sarcoidosis[13] is not clear. Many believe it to be a benign form of tuberculosis, basing this on the following:

1. The histologic similarity between the two conditions.
2. Occasional recovery of tubercle bacilli in sarcoid cases.
3. Reported cases terminating in frank tuberculosis.

Against the concept that this is a benign form of tuberculosis, are the following:

1. Tubercle bacilli usually cannot be demonstrated in these cases either by culture or animal inoculation.
2. Approximately 60 to 80 per cent of the cases fail to show a positive reaction to tuberculin.[14]

Other possible causes of the disease have been based on the blood picture findings. A high eosinophil count in some cases suggests the possibility of allergy. A neutropenia and leukopenia have sometimes been noted, suggesting that a virus might be the cause. However, at present, the etiology is obscure.

The pathologic findings are characteristic and no matter what part of the body is involved, the lesions are similar. The typical lesion is about the size of a miliary tubercle and is composed of pale staining polygonal epithelioid cells. There is no peripheral inflammatory zone about the nodules and the caseation, which is characteristic of tuberculosis, is absent. Langhan's type giant cells with as many as twenty nuclei are present, but are not numerous. The skin, lymph nodes, lungs, bones, liver, and spleen are most commonly involved, but no organ in the body is exempt.

Clinically, one is confronted with a variety of

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syndromes depending on the organs involved. Probably the commonest initial finding is enlarged lymph nodes. Pulmonary lesions are also frequent with symptomatology depending upon what parts and how much of the lung parenchyma is involved. King[15] found that 60 per cent of the lung cases resolved within three years, the average being about twenty-two months. Bone lesions usually involve the phalanges, metacarpals, and metatarsals. Any structure of the eye may be involved resulting in a conjunctivitis, keratitis, iridocyclitis or uveitis. In some cases the parotid gland may be affected along with the eye, giving rise to the syndrome of uveoparotid fever. Johnson and Jason[16] recently reported a case of generalized sarcoidosis in which there was a massive infiltration of the myocardium. Salvesen[17] in 1935 first recorded a case of myocardial involvement resulting in a bundle branch block. Heart failure, arrythmias, and significant electrocardiographic changes have been reported. Cardiac function may be secondarily disturbed by extensive pulmonary involvement, thereby producing a cor pulmonale with right heart failure. The liver, spleen, intestinal tract, and kidneys may be involved. Rotenberg and Guggenheim[18] reported a case of sarcoidosis in which renal insufficiency and hypertension may have been due to sarcoid invasion of the kidneys. Klinefeiter and Salley[19] recently cited a case of sarcoidosis with renal insufficiency that simulated glomerulonephritis.

Sarcoidosis may have few constitutional symptoms. Weakness, fatigue, anorexia or arthralgia may occur. Symptoms are caused by mechanical interference with the organs rather than by any form of intoxication. The clinical picture of thrombocytopenic purpura associated with sarcoidosis is unusual. The course of the disease is chronic, usually not fatal unless vital organs are involved. Some show spontaneous recovery. Although there is no specific therapy, some cases with large nodes have improved very much with radiation therapy in spite of the fact that some observers[20] believe this to be radioresistant.

PURPURA

Purpura is produced by the extravasation of the blood into the skin, subcutaneous tissues, mucous membranes, and internal organs. It is due to multiple causes, and hence it is observed in many otherwise unrelated conditions. There are three fundamental immediate causes for a hemorrhagic diathesis:

1. A defect which renders the capillary walls more permeable.
2. An abnormality in the plasma of the substance responsible for blood coagulation.
3. A reduction in the number of blood platelets.

In some instances, more than one mechanism may be active. Thrombocytopenic purpura (decreased platelets, delayed bleeding time, and normal coagulation time, non-retractable clot, positive tourniquet test) may be divided into two large groups; namely, (A) idiopathic thrombocytopenic purpura (Werlhof's Disease) and (B) secondary or symptomatic thrombocytopenic purpura where a definite cause of the disease may be found. It is of utmost importance to distinguish between the two, since in the former, splenectomy may cure the patient whereas in the latter, splenectomy is contra-indicated, and treatment must be directed to the primary cause. The role that other diseases such as tuberculosis or sarcoidosis plays in thrombocytopenic purpura remains unanswered.

CASE REPORT

A forty-six year old white male first reported for examination on May 2, 1946. For three years he had noticed black and blue spots about different areas of his body. These would slowly clear up, but were followed by others. During this time he had had frequent nasal hemorrhages for which he had been treated by nasal cauterizations. Eventually this led to a submucous resection because of a "hole" in his septum. During this time he had been complaining of "weak spells and exhaustion", and had been receiving vitamin K almost continuously.

In May 1945 he developed a toxic goiter, and in August a thyroidectomy had been done. This operation had been performed during the time the ecchymotic areas had been appearing over the body. The blood picture had been normal as far as could be determined, and his postoperative course had been

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uneventful. The purpuric spots have continued up to the present. The past history was essentially negative excepting for a prostatitis in 1941. At this time, retrograde pyelograms had revealed two kidneys with two kidney pelvises on each side, but only three ureters, two being on the right side and one on the left.

He was a well developed, well nourished, adult white male not acutely ill, but exhibiting some apprehension. There were several purpuric areas over the body in various stages of absorption, the lower third of both legs being almost entirely ecchymotic without evidence of absorption. There was a moderate degree of exophthalmos with a well healed thyroidectomy scar. The spleen was barely but definitely palpable on deep inspiration.

Fluoroscopic examination of the chest did not reveal any abnormalities. Three basal metabolism studies done on May 5, 1946, December 2, 1946, and March 27, 1948, were minus 4, plus 5, and plus 7, respectively. The electrocardiogram in December 1946 revealed an increased QRS conduction time to 0.12 seconds. Other than this, the tracing was normal. A second electrocardiogram on September 29, 1949, was similar to the one taken in December 1946. The laboratory record of this patient shows a text book adherence to the requirements for a thrombocytopenic purpura diagnosis. In July 1946, he had a platelet count of 40,000 (Gay and Leake counting method) confirmed by the blood smear estimate procedure. Prothrombin time was 100 per cent of normal. Serum Vitamin C was at the lower limit of our normal range (0.7 milligrams per cent). Bleeding and clotting times were 14½ and 3½ minutes respectively. The latter test was that of Lee & White. There was no clot retraction at either room or incubator temperature. The blood count showed 14.5 Grams of hemoglobin with 4.56 million red cells. The white count was 9,200 with 76 per cent polymorphonuclear cells. The eosinophilic count varied from one to eight per cent. The three highest counts were 3, 7, and 8 per cent. The tourniquet test was positive. Bone marrow examination indicated a cellularity of 184,000 per cubic millimeter with 198 megakaryocytes and a marked paucity of platelets. The differential of the bone marrow cells was normal.

By December of 1946, the platelet count went down to 25,000. On admission to the hospital he had a B.U.N. of 17 milligrams with a total cholesterol of 214 milligrams per cent. All other laboratory work was non-informative and a splenectomy was done on December 10, 1946, by Dr. Norman Dingman. Two transfusions of compatible blood were given during the operation without reaction. On December 12, the platelets had risen to 70,000 with 13.5 Grams of hemoglobin, 4.2 million red cells and 37,000 white blood cells, of which 92 per cent were polymorphonuclears. The following day the leucocytes rose to 41,000 with essentially the same differential distribution. The platelets now were 140,000. On the fifteenth of December the platelets had risen to over 500,000. The bleeding time was one minute, clotting time was four minutes, and the clot retraction was complete in 30 minutes. On December 20, the platelet count had receded to a normal of 300,000 with a bleeding time of 1½ minutes, a clotting time of 4½ and a clot retraction complete in 75 minutes.

In July 1947, a laboratory study noted 14.6 Grams of hemoglobin with 5.14 million red cells. Platelets were 210,000 with bleeding and clotting times of 2 and 5 minutes respectively. Clot retraction was complete in 1½ hours. September 30, 1949, the blood showed 14.0 Grams of hemoglobin with 4.42 million red cells. Platelets were 230,000 with bleeding time 2 minutes and clotting time 5 minutes. Clot retraction was complete in two hours. The tourniquet test was negative.

The spleen measured 15 x 8.5 x 4.0 centimeters and weighed 291 Grams. The surfaces appeared slightly brownish and showed many slightly elevated areas, varying from 5 to 20 millimeters in diameter, all being beneath the capsule. On gross section, the surfaces showed reddish-brown splenic tissue which was somewhat elastic in consistency and which sank slightly beneath the capsular edge. The nodular areas were fairly well circumscribed and appeared slightly hemorrhagic. The Malpighian corpuscles were not distinct, but could be made out. Microscopic sections revealed many tubercles with giant cells of Langhan's type. (See figures 1 and II). The splenic tissue in the uninvolved portions showed no significant pathologic changes. Diagnosis was sarcoidosis of the spleen.

Histologically, the spleen is the second most common site for sarcoid involvement, the lungs being the first.[21] Its confusion with tuberculosis can readily be understood because of their similarities. Winternitz[22] in 1912 reported 51 cases of tuberculosis of the spleen. These cases have been reviewed by others who believe that some of them were sarcoidosis. This case also at first was thought to be tuberculosis, but on further investigation was believed not to be so. X-ray of the chest was normal, and the tuberculin test was negative. No acid-fast bacilli were found on staining a section of the spleen.

The prolonged bleeding and clot retraction times, reversed by the splenectomy, were most characteristic of the diagnosis. The course of this case and the bone marrow findings indicated hypoplasia of the thrombocyte forming mechanism. The need for splenectomy, confirmed by the postoperative course, was inferred above all by the presence of ample megakaryocytes. The hemorrhagic tendencies have completely ceased since operation. Other than an occasional headache plus complaints of weakness and fatigue at times, the patient has

21. Freedman, M.: American Journal of Pathology, 20:621 (1944).
22. Winternitz, M. C.: Archives of Internal Medicine, 9:680 (1912).

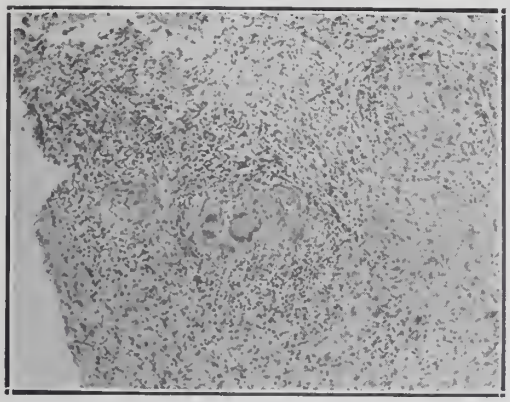

Figure 1. Sarcoid spleen showing tubercles and Langhan's cells. (Magnification 100 X.)

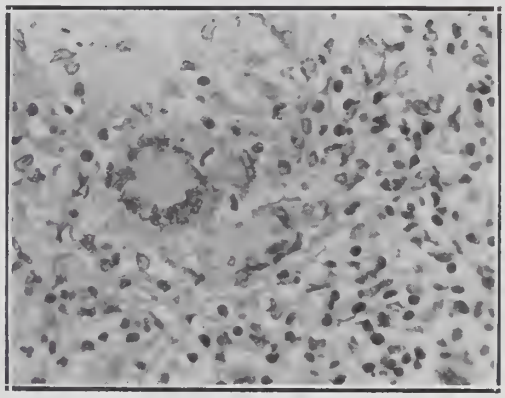

Figure 2. Sarcoid spleen showing Langhan's cells with many nuclei. (Magnification, high power 250 X.)

been doing well since his splenectomy in 1946. Recently, he had several small punched-out ulcerated areas on the right leg just above the ankle, probably due to an impairment of his deep venous return. This has responded well to conservative treatment.

SUMMARY

1. The evolution of the belief that sarcoidosis is a systemic disease with a variety of constitutional symptoms is traced in the literature.

2. Its relationship to tuberculosis as a possible etiologic factor is discussed.

3. Clinically, sarcoidosis is characterized by the involvement of one or several organs of the body with comparatively little symptomatology.

4. A case of sarcoid spleen is presented associated with thrombocytopenic purpura with complete recovery of bleeding tendencies following splenectomy.

559 Broadway

ACCOLADE TO DR. TARBELL

At a recent meeting, the Physicians Club of Essex County adopted the following resolution:

WHEREAS, Dr. Harold Tarbell has entered upon his fiftieth year in the practice of medicine: and

WHEREAS, In his strategic position as city bacteriologist he has by his prompt and accurate diagnoses of diphtheria saved the lives of many children: and

WHEREAS, His work in the Society of Widows and Orphans of Medical Men of New Jersey has demonstrated his intense interest in the economic status of the profession at large: and

WHEREAS, The Physicians Club of Essex County has never had a better secretary. His classic minutes have the accuracy of Charles Dickens and the wit of Robert Benchley. Therefore be it hereby:

RESOLVED, That a copy of these resolutions be spread upon the minutes and that all members of the Physicians Club of Essex County extend to Dr. Tarbell our sincere thanks for his faithful service: our deep appreciation of his accomplishments with the hope that he will continue to serve us for many years to come.

STERILITY-FERTILITY AWARD

The American Society for the Study of Sterility offers an annual award of $1000 known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice. Essays submitted for the 1951 contest must be received not later than March 1, 1951. For full particulars, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

MANAGEMENT OF SUSPECTED POLIOMYELITIS

Arthur B. Light, M.D.,* Lawrenceville, N. J.

The role of the general practitioner during a poliomyelitis epidemic, or whenever confronted with a suspicious case, is largely limited to making a proper diagnosis. If the history, symptoms, and physical signs make him doubly suspicious, he is then faced with the decision as to whether the patient should remain at home for further developments or be sent to the nearest hospital for study and specialized treatment. The position of the family doctor during these trying hours or days is not enviable.

The writer has been a general practitioner during the past nineteen years among a large group of adolescent males during the school year. During the summer months, for the past decade, I have engaged in general practice among children and adolescents. In both practices I have been continuously harassed by parents of children with undiagnosed fevers during the summer months, particularly if there is a recognized case of poliomyelitis in the neighborhood or an epidemic in the vicinity. To give these parents a sense of utility and allay their apprehension, a routine of management has been evolved during the past ten years which is utilized whenever there is the slightest possibility of early poliomyelitis.

During this time, some sixty patients have been treated during the "poliomyelitis" months. All had undiagnosed fevers with varying degrees of stiffness of the neck or backache. Complaints of severe headache, sore throat, nausea and vomiting, and nervousness were frequent. Twenty-eight also had definite disturbances of the muscles such as pain, numbness, or weakness in one or more extremities. One had slight difficulty in swallowing. Many gave histories of chilling or of engaging in strenuous exercise after a day or two of "not feeling well". Seven of the twenty-eight patients were treated during the past summer with a severe epidemic raging only ten miles away. A brief summary of the history and symptoms of five of these cases follows:

1.—White male, aged 5, was first seen at home August 29, 1949. His temperature was 102.3. He complained of headache, stiffness of the neck, and pain and weakness in both legs. There was demonstrable weakness of both legs, more marked in right. The mother said the patient had not been "his usual self" for several days. He woke up on August 29, vomiting and refusing breakfast. Toward noon, he felt much better and insisted on going to the beach. After being in the water for ten minutes, he complained that his head and legs "hurt". He had to be carried home. Treatment began at 5 p. m., with first visit. Leg symptoms started to abate at end of 36 hours, and disappeared at end of 48 hours. Stiffness of the neck lasted three days.

2.—White female, aged 11, was first seen at a hotel August 10, 1949. Her temperature was 101. She complained of sore throat, stiffness of neck, and pain in right shoulder and arm. There was equivocal weakness of right arm and shoulder. She gave a history of slight sore throat for several days but insisted on going bathing noon of August 10. Symptoms began several hours later. Treatment started on first visit. Arm symptoms completely subsided in 24 hours, stiffness of neck in 36 hours. She was symptom free in 48 hours.

3.—White male, aged 16, was first seen at 8 p. m., August 18, 1949, with a temperature of 103.2. He had severe headache, sore throat, stiffness of neck, and numbness of both arms, but there was no demonstrable weakness in either arm. On that morning, he had dragged his sailboat out of water and spent most of the day scraping it in the hot sun. He then went for a swim in ocean. Several hours later, these symptoms started. Treatment was initiated immediately. Arm symptoms were gone next day at noon. Patient was symptom free in 48 hours.

4.—White male, aged 19, was first seen at 7 p. m., July 30, 1949, at home. Temperature was 101.8. He complained of severe headache, backache, and marked pain and weakness of both legs. Definite demonstrable weakness of both legs was present. He had felt "very tired" for several days prior to onset of symptoms. Father attributed fatigue to "late hours", and as a punitive measure, insisted that the boy "get busy and paint the house". He started this chore on the morning of July 30. Shortly after luncheon he felt hot and tired. He attributed this to climbing the ladder several times during the morning. He went for a swim and while in the water was seized with chill. Other symptoms followed in rapid succession. Treatment started at once. Leg symptoms started to abate in 48 hours and were completely gone in three days. Backache persisted for five days.

* Medical Director of The Lawrenceville School.

5.—White female, aged 34, was treated at my office for mild sore throat, no fever, August 20 and 21, 1949. On the morning of August 23, she awoke with nausea, backache, extreme "nervousness", and stiffness of both legs. There was no demonstrable weakness of either leg but power was slow in developing. Temperature was 100. Treatment was started at once. Leg symptoms were present for three days, backache for four days.

COMMENT

Probably many of the sixty patients never had poliomyelitis. Some may have had the nonparalytic type. Others might have done just as well without any treatment. Yet, dealing with a large group of children and adolescents, I feel that somewhere along the line, especially among the more "suspicious" cases, I should have run into trouble. During this period, not a single patient developed residual paralysis nor was it necessary to send a patient to a hospital for specialized treatment. All were symptom free in from two to five days.

This management technic is being reported in the hope that it will be put to further test by the general practitioner whenever he suspects early poliomyelitis. The routine is simple, easily carried out in the home, and can do the patient no harm. It is largely empirical, yet, except for the chemotherapy, has as much physiologic justification during the early phase of the disease as the controversial hot pack treatment.

MANAGEMENT TECHNIC

The patient suspected of having poliomyelitis is immediately placed between blankets. One or two more are added so that the patient will have a definite feeling of warmth. Hot water bottles or electric pads are placed close to the body depending upon the locale of the muscular symptoms. If the patient has signs in the upper extremities, the local heat is kept in this region. If the lower extremities show any signs of being involved, the local heat is placed between the thighs; or if only one limb is involved, placed at the site of greatest discomfort. Stiffness of the neck and backache are treated in similar manner. The temperature of the hot water bottles or the electric pads is immaterial as long as it feels comfortable to the patient. The patient must be kept between the blankets day and night as long as any symptoms persist. Local heat is maintained "around the clock" until the discomfort for which it was applied has subsided.

Some patients complain of being too warm during the first hour or two, especially if the fever is high. But soon thereafter they become quite comfortable and wish the heat continued. Occasionally young adults complain of being uncomfortable but when informed that it might be wise to suffer some discomfort for several days to avoid the possibility of permanent disability, their protests rapidly subside.

Despite the blankets and local heat, the temperature often drops to normal within forty-eight hours. Sweating may be profuse. To combat the salt loss, one or two salt tablets are given daily. The patient is advised to slake his thirst with fruit juices, ginger ale, or water. The diet is immaterial as long as it is reasonable. The room must be kept warm at all times to avoid chilling. The patient should be kept in bed at all times if possible. If not, a commode or bed chamber should be used.

Antipyretics are not used during the febrile stage in order not to interfere with the body's heat regulating mechanism. Headache is treated with codeine or ice bag.

At the very onset of the treatment, the patient is given calomel (or "calomel and soda") in divided doses depending on the age and weight of the patient. The minimum dose has usually been not less than one-half grain and the maximum a grain and one-half. If minimum doses are used, a tenth of a grain is given every fifteen minutes; if maximum doses, quarter grains every half hour. A saline purgative is given about eight hours after the last dose, or early the next morning.

RATIONALE

Present active treatment during the early and acute stages of poliomyelitis is directed chiefly to the muscles for the relief of pain and muscle spasm and to prevent contractures and subsequent deformities. Yet the basic struggle against permanent pathologic damage is fought, not in the muscles, but in the central nervous system, particularly in the anterior horn cells. Fifty per cent of all patients escape paralysis and 25 per cent have only mild

physical limitations. This suggests that the anterior horn cells offer considerable resistance to the invading virus. It is also logical to assume that, given additional aid early in the disease, this resistance may be greatly enhanced. A hint in this direction comes from the work of Galloway and Seifert,[1] who by keeping the respiratory passages free from accumulated secretions and thereby insuring a better oxygen supply to the central nervous system, had fewer deaths among their cases of bulbar paralysis. Such aid can also be given to the deeper structures including the central nervous system by increasing the blood flow and metabolism which are concomitant with a febrile reaction. It is for this reason that antipyretics are avoided during this treatment as they tend to divert to the surface blood which might presumably be of better use to the deeper structures. The continuous use of blankets and local heat helps the heat regulating center maintain the febrile reaction.

Fever therapy has been tried by Stone[2] and by Bundensen.[3] Stone[2] obtained excellent results with cases seen early in the course of the disease. Bundensen[3] came to the conclusion that fever therapy was no better than the "hot pack treatment" of Kenny. He did not state how long his patients had been ill before fever therapy was used. Neither of these investigators sought to maintain the febrile reaction "around the clock", no doubt due to the high fevers developed by their technics. Blankets and local heat do not tend to increase greatly the existing body temperature and can therefore be used "around the clock". As a matter of fact, as mentioned previously, the temperature often drops to normal within 24 to 48 hours despite these appurtenances.

The use of calomel (or calomel and soda) must, for the present, be looked upon as purely empirical. It was originally prescribed to keep a frantic mother busy giving "medicine" every fifteen minutes. The patient, a male aged 14, besides being constipated had a temperature of 102, and complained of severe headache, stiffness of the neck, and had demonstrable weakness of the right arm. The striking improvement in the arm the next day and complete recovery in 48 hours left such an impression on me that I have been using it ever since. Calomel was used alone with local heat for several years before blankets were incorporated in the treatment. In 1942, Schultz and Robinson[4] tested 112 chemical agents against the virus MVA *in vitro* and found that 33 of these substances had an inactivating effect. Of these 33, mercuric chloride ranked among the most potent. On the basis of this work, there might be a remote possibility that while the purgative action of calomel is evacuating some of the virus from the intestinal tract, its presence might also have some inhibitory effect on the virus.

SUMMARY

A simple, harmless program of management for suspected poliomylitis is reported. It is easily carried out in the home and gives the family the feeling that, at least, something is being done for the patient.

1. Galloway T. C., and Seifert, M. H.: Journal of the American Medical Association, 141:1 (September 3, 1949).
2. Stone, S.: Journal of Pediatrics, 22:142 (February 1943).
3. Bundensen, N. H.: Personal communication (November 1949).
4. Schultz, E. W., and Robinson, F.: Journal of Infectious Diseases, 70:193 (March 1942).

GASTRO-ENTEROLOGISTS HONOR DR. H. I. GOLDSTEIN

At a recent meeting, the New Jersey Gastro-Enterological Society adopted the following resolution with reference to Dr. Hyman I. Goldstein.

WHEREAS, Dr. Hyman I. Goldstein of Camden, N. J., one of the charter members of the New Jersey Gastro-Enterological Society possesses profound knowledge of medical history and has made most valuable contributions to the medical literature in this field and;

WHEREAS, he has won and retained the admiration and respect of his colleagues who recognized in him a fine gentleman, a great scholar, an astute clinician as well as a noted medical historian;

BE IT RESOLVED, that the New Jersey Gastro-Enterological Society fittingly honor their most gifted member, Dr. Hyman Goldstein by tendering him a testimonial dinner at Asbury Park, N. J.

ENDOMETRIOSIS

VAGINAL SMEAR FINDINGS AS AN AID IN DIAGNOSIS AND IN THE EVALUATION OF TREATMENT

GRACE T. NEWMAN, M.D., Montclair, N. J.

I have found the vaginal smear a useful aid in the diagnosis of endometriosis. Using the Shorr technic[1] I do routine vaginal smears on all patients. I find that the smear characteristic of endometriosis is the hyperestrin type. In this kind of smear, leukocytes are scant. The large cornified cells with small or pyknotic nuclei predominate and stain a deep pink. This is the smear we see in the follicular phase of the menstrual cycle, and also when estrogen is given for full estrogenic effect. It also occurs in some types of anovulatory cycles. When these conditions can be ruled out, the *finding of large discrete pink cornified cells throughout the cycle is diagnostic of endometriosis.* Patients who have adenomyomas frequently show an increased number of cornified cells during the menstrual cycle but to a lesser degree than patients with endometriosis. The study of the vaginal smear is also of great assistance in evaluating the amount of testosterone therapy to be given. Postoperatively it is a guide in recognizing any reactivation of the condition if it should recur. It is our chief way of knowing whether the patient should be given estrogen postoperatively and in what dosage. The use of the vaginal smear in gynecologic conditions has been discussed by the author in a previous paper.[2]

Hyperfunction of the ovaries is related to endometriosis. This is demonstrated by the fact that surgical removal (or atrophy of the ovaries with the use of radiation or male hormone) causes a regression of the condition or cures it entirely. That estrogen causes increased growth of the implants has been used[3] to substantiate the diagnosis. I have also seen it necessitate further surgery in patients thus increasing the morbidity of the operation.

Three theories have been offered to explain the pathogenesis of endometriosis. One is that embryonal implants of ovarian epithelium have a common origin with the mullerian epithelium. This misplaced tissue takes on the function of endometrial epithelium and accounts for islands of endometrial tissue found in the ovary. Another theory is that endometrial transplants are cast off through the fimbriated ends of the fallopian tubes during menstruation and become attached to the peritoneal surfaces. The third theory is that endometrial cells are transmitted via the lymphatic vessels at the time of menstruation and pass to neighboring structures and may indeed reach the lung. Whatever the cause, the usual structural unit is an endometrial-walled cyst which menstruates into its own lumen. The invasion is opposed by the growth of fibrous tissue. The seeping menstrual fluid plasters the ovary first to the broad ligament and later to any contiguous areas. Droppings from an ovarian endometrioma become the so-called "blueberry spots" which may occur in groups and coalesce. Internal endometriosis or adenomyosis may occur concurrently. This occurred in 60 per cent of the cases I am going to discuss in this paper. Long-continued administration of estrogen in guinea pigs has produced fibromyoma experimentally. These tumors regress or go away entirely with the administration of progesterone or testosterone. During pregnancy the endometriosis regresses. Is this due to the physiologic amenorrhea or the effect of the corpus luteal hormone?[2] In the doses given today, progesterone has not regressed the condition in the human being.

What is the mode of action of testosterone in alleviating this condition? According to Carter, Cohen and Shorr,[4] androgens suppress the development and secretory activity of the

1. Shorr, E.: Science, 94:544, (December 1941).
2. Newman, Grace T.: Medical Women's Journal, 54:20, (October 1947).
3. Freiheit, J. M.: Connecticut Medical Journal, 11:965 (December 1947).
4. Carter, A. C., Cohen, E. J., and Shorr, E.: Vitamins and Hormones, 5:317, (November 1947).

corpus luteum. To do this they must be given during the first half of the menstrual cycle in large doses. They then suppress the secretory phase and the endometrium shows a proliferative pattern or varying degrees of regression from hypoplasia to atrophy. Testosterone is an effective therapy but the accompanying hirsutes, acne and voice changes make it unsatisfactory over a long period. It is also a very expensive form of therapy. It is the treatment of choice in the child-bearing woman unless complications require surgery at an early date.

Endometriosis is on the increase and must be recognized and treated properly. It may occur at any age during the menstrual life of an individual. As one observer has said: "it occurs in married women who are not having children". Women often delay pregnancy for various reasons, chief of which is the economic factor. Some clinicians have observed a higher ratio of cases in private practice than in clinics. There is evidence that clinic patients have their children at an earlier age. We do not know what causes the increased estrogen output. Perhaps the lack of vitamin B may be a contributing factor, as the liver loses its ability to inactivate estrogens in B complex deficiency thus permitting excess estrogen to be undestroyed in the body. Many diets today are deficient in B vitamin and this is often true of the diet in women.

The age of the patient varies. Allen and Galloway[5] report 16 cases in a series of 381 student nurses between the ages of 17 and 34. Chief symptoms are severe dysmenorrhea, irregular and heavy menses, dyspareunia, constipation or rectal pressure and sterility. Fallon, Brosnan and Moran[6] have reported diagnostic significance in increasing pelvic pain associated with a change in the time and the amount of the flow. They also noted pain on movement of the cervix on vaginal examination and the extreme hardness of the nodules when palpated.

In my series of 35 patients whose ages varied from 28 to 50, 55 per cent had had severe dysmenorrhea; 70 per cent had "heavier than normal" menstrual flow and in 60 per cent the uterus was displaced backward. In *all* the patients there were palpable masses either in the uterus, adnexal region or the posterior vaginal vault. Twenty-four (70 per cent) underwent complete hysterectomies. Of those operated upon, 61 per cent had endometriosis of the ovary, 35 per cent of the uterus, 2 per cent of the sigmoid and 2 per cent of the appendix. Twenty-eight patients were seen prior to any pelvic surgery. In these patients, 82 per cent showed the hyperestrin type of smear. In the other seven patients who were seen postoperatively, five showed atrophic smears and two patients had the hyperestrin type. One of these had been on estrogen therapy the other had not, but this patient still had one ovary left *in situ*.

In observing patients with endometriosis I have noted several interesting facts. For instance, after complete hysterectomy the vaginal smears usually show a definite menopausal picture which we would expect. However, this does not occur in all patients. Some show (for months or years) varying amount of cornified cells, which indicate the presence of estrogen. It may be possible that bits of ovarian tissue are left behind and resume function or that the adrenal gland takes up the production of estrogen. With the persistence of the hormone, as indicated by the vaginal smears, I do *not* think that estrogen should be given postoperatively as it may be the spark which rekindles the endometriosis. I think it should be given only in the presence of severe menopausal symptoms and when the vaginal smears show an atrophic picture; and then, in a minimum dosage with frequent rest intervals and accompanied with regular vaginal smear studies. I seldom use more than 0.5 milligrams of dienestrol or 1.25 milligrams of premarin per day with a rest interval of one week every 3 to 4 weeks. Kimbrough and Israel[7] feel that estrogens are definitely contra-indicated. Two of the patients in my series required second operations because the condition was reactivated with the giving of estrogen in too large dosages. In recurrence, we find pelvic pain the predominating symptom. On examination of

5. Allen, E. and Galloway, Clarisse: Gynecology, 53:290 (February 1947).
6. Fallon, J. *et al.*: New England Journal of Medicine, 235:669 (June 1946).
7. Kimbrough, R. A. and Israel, S. L.: Journal of the American Medical Association, 138:1216 (December 25, 1948).

the vaginal smears we find the hyperestrin type of smear.

The general health of the endometriosis patient is usually good except for the disabling menstrual periods or anxiety caused by the dyspareunia or the sterility. The high level of estrogen produces a sense of well-being. Painful breasts are not as common a finding as I would expect. Three of the patients in my series showed mastitis. There is usually a concomitant leukorrhea due to the cellular exfoliation. We also see this in patients who are under heavy estrogen therapy for other conditions. We would not expect menopausal symptoms and rarely find them in endometriosis except after castration.

The treatment generally accepted today is that of conservatism during the child-bearing years, with testosterone to control the dysmenorrhea. Many patients have become pregnant while under testosterone therapy. After the child-bearing era has passed, the treatment of choice is a complete hysterectomy. The use of testosterone is distasteful to many women due to the annoying side effects and because of the need for constant injections.

SUMMARY

The vaginal smear is a helpful aid in the diagnosis and postoperative follow-up of the endometriosis patient. There is a definite increase in the number of these patients. The vaginal smear is also a great help in evaluating the dose of testosterone which will convert the vaginal smear from a hyperestrin type to the atrophic or menopausal smear. If menopausal symptoms are severe after hysterectomy small doses of estrogen may be given cyclically with frequent intervals and study of the smear response. Estrogen is contra-indicated in patients who show persistence of cornified cells in their smears postoperatively due to the danger of possibly reactivating the condition. Pregnancy should be encouraged at an earlier date following marriage. Diet with adequate amounts of vitamin B should be given. The exact cause of this interesting condition has not yet been established.

339 Grove Street

RUPTURE OF THE TENDON OF THE TIBIALIS ANTICUS

PAUL STRASSBURGER, M.D., Belleville, N. J.

Rupture of the tendon of the tibialis anticus is apparently a rare lesion. Only six cases[1] have been recorded in the literature. McMaster[3] has shown that the normal tendon practically never ruptures when subjected to stress. The musculo-tendinous junction or the bony attachment of the tendon gives away first. Els[2] has confirmed this by his work on the cadaver.

CASE REPORT

A 64-year old man was first seen on March 19, 1948, because of pain on the dorsal surface of the left foot and a left limp. Two months earlier, he had slipped on the icy steps of his house. He skidded down three steps, landing on his heels on each step and twisting the left foot. He had immediate pain across the dorsal surface of the left foot. The pain improved after a few days but a slight limp remained. On March first he again twisted the left foot and the pain returned. On March 17, he tripped while crossing the street and caught the toe of his left foot. There was again immediate pain on the dorsal surface of the left foot and the limp became more pronounced.

He walked with a marked left drop foot. There was localized pain, swelling and tenderness over the dorsal aspect of the left foot in the region of the insertion of the tibialis anticus tendon. There was no palpable or visible contraction of the anterior tibial tendon on attempted active dorsiflexion of the left foot and there was a prominent tendon on the right. The Phelps reflex (contraction of the anterior tibial on flexion of the hip with the knee flexed) was not present on the left. The tendons of the extensor hallucis longus, posterior tibial and peroneals all could be felt on active con-

1. Bruning, E.: Muenchner Medizinische Wochenshrift, 52:1929 (December 1905); *also*, Burman, M. D.: Annals of Surgery, 100:368 (February 1934) *and* Lapidus, P. W.: Bulletin of the Hospital for Joint Diseases, 2:119 (July 1941).

2. Els, H.: Deutsche Zeitschrift fur Chirurgie, 106:610 (June 1910).

3. McMaster, P. E.: Journal of Bone and Joint Surgery, 15:705 (November 1933).

traction of their respective muscles. The dorsalis pedis pulse was of good quality.

Roentgen examination of the left foot showed no evidence of any recent or old fracture or dislocation.

The tenative diagnosis was: either of rupture of the left anterior tibial tendon close to insertion, or avulsion of the tendon from its insertion. Because of the rarity of the lesion, Dr. Leonidas Lantzounis was asked to see the patient in consultation. He concurred in the diagnosis and agreed that surgical correction was indicated. The patient was admitted to New York Orthopaedic Hospital and on March 23, 1948, operation was performed.

The anterior tibial tendon was exposed through an eight inch incision along its course extending upward from the base of the first metatarsal. The sheath of the anterior tibial tendon was considerably thickened and contained about five cubic centimeters of old blood. There was a loss of continuity of the anterior tibial tendon three-quarters of an inch from its insertion. There was a separation of 1¼ inches between the parted ends of the tendon. The proximal end was bulbous and frayed. There was both recent and old hemorrhage throughout its course. It was partly adherent to the tendon sheath.

The proximal end of the tendon was freed and three-quarters of an inch of the distal degenerated stump was removed. A Bunnell interlacing heavy black silk suture was placed in the proximal end of the tendon and this was tied through a drill hole in the medial cuneiform bone. The approximated ends of the tendon were then sutured with interrupted fine silk sutures. The tendon sheath and the skin were closed with interrupted black silk sutures. A circular plaster was applied with the foot at eighty-five degree of dorsi-flexion and in supination.

The pathologic report by Dr. C. Zent Garber, on the tissue removed, is as follows:

"*Macroscopic:* Consistency is much softer than normal tendon. Some smooth surfaced thin blood-clot adheres to the surface. One end of the specimen terminates in small rounded strands of fibrillated tissue representing ruptured fibers."

"*Microscopic:* The sections sbow dense fibrous tissue in pattern of tendon witb extensive areas of old hemorrhage scattered about and separating groups of fibers, often quite widely. Mere shadows of red blood cells are recognizable in some of the zones of bemorrbage. Peripherally tbere is some newly formed connective tissue containing numerous small blood capillaries. The longitudinal section shows its distal end some splitting and fraying and at the surface, fibrin clot formation."

Postoperative course was essentially uneventful. On the sixth day after operation the plaster was changed and wound found to be clean. A walking boot was applied with the foot at ninety degrees of dorsi-flexion. Four weeks after operation the walking plaster was removed and on attempt at active dorsi-flexion, the anterior tibial tendon was seen to contract. The patient was then ambulatory with a spring type foot drop brace. Eight weeks after operation, there was active motion from 90 to 115 degrees. The patient was allowed to discard the brace at home, but continued to use it on the street.

Ten weeks after operation he was advised to discard the brace. The ankle motion was active from 90 to 120 degrees with good power in the anterior tibial and the patient could walk with only a slight limp. There was slight pain in the region of the ankle at the end of the day. Six months after operation, there was only an occasional "weather ache" and a slight limp after walking all day.

SUMMARY

From the history and the findings of this case it would seem that this patient, at the time of the original injury, had a partial tear of the anterior tibial tendon. He then completed the rupture at the subsequent injury. Why the tendon was weak at the point of rupture is not apparent. In some cases reported in the literature[4] there had been previous injury to the dorsal surface of the foot before the rupture of the anterior tibial tendon occurred.

330 Washington Avenue

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NEW MERCK MANUAL AVAILABLE

The eighth edition of *The Merck Manual of Diagnosis and Therapy* is now available. This completely rewritten "Golden Anniversary Edition" is a concise reference source of information on the remarkable advances in medical science during the past decade. The first edition was published in 1899, and the last preceding edition in 1940. The current edition is replete with up-to-date information, including current knowledge on antibiotics, the sulfonamides, and the anticoagulants, and on therapy employing adrenocortical steroids or substances of related action.

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LESIONS OF COLON AND RECTUM *

DIAGNOSIS AND TREATMENT

FRANK S. FORTE, M.D., Newark, N. J.

The purpose of this paper is to bring to your attention, and re-emphasize if necessary, some of the more important large bowel lesions.

That a carefully taken history has one of the top priorities is undisputed. Following this, digital palpation, proctosigmoidoscopy, x-ray studies, et cetera, constitute the backbone of our examination. These investigations should be based on an adequate knowledge of the embryology, anatomy and physiology of the large bowel in order to appreciate thoroughly its disorders.

One of the commonest terms associated with the large bowel is colitis. Strictly speaking the term colitis means inflammation of the colon; but in the broader sense[1] it includes all diffuse inflammatory diseases of the large intestine, including structures from the cecum to the anus.

In 1896, Mathews[2] classified large bowel disorders into one of the first comprehensive clinical arrangements. Interestingly enough, congestion, inflammation, and simple ulceration under his classification were only stages of one disease process, all caused by constipation. His description of simple ulceration tallies with our "chronic ulcerative colitis".

In contrast Bargen[3] divided chronic ulcerative colitis into nine types of cases. In type 1, *colitis gravis* (or thrombo-ulcerative colitis grouping) owing to the frequency of occurrence, the clinical, proctoscopic and roentgenologic manifestations conforming to a definite pattern he uses this type of ulcerative colitis as a norm. Other types are described principally by noting in what respects they differ from it.

It is evident therefore that the diagnosis of chronic ulcerative colitis is facilitated by proctosigmoidoscopy, x-ray manifestations and stool examination plus a study of the clinical course. Medical treatment has run the gamut from Mathews' time with irrigations of solutions of hydratic et cetera, on through Bargen's vaccine reaching the more recent phases of the use of drugs of the sulfonamide family. All are familiar with sulfasuxidine, sulfathalidine thalamyd and now nisulfazole is appearing in the literature.

Penicillin, streptomycin and other antibiotics have also added immeasurably to our armamentarium. Nor is the proper place of blood transfusions, blood plasma, vitamines, water N balance as well as diet to be overlooked.

After medical treatment the improvement may be temporary. It is impossible to say that after any given period of freedom from activity the disease will not recur.[4]

Some feel that many patients are lost because of unwillingness to accomplish radical surgical intervention. Surgical intervention should be delayed until two factors have been evaluated:

1. The response to conservative treatment.
2. The extent and distribution of permanent damage to the colon.[5]

Specifically Cattell[7] sets forth the indications of surgery as follows:

1. Intractability to medical treatment.
2. Incapacity for three months or more in each year.
3. Subacute perforations and abscesses.
4. Fistula or sinuses.
5. Massive hemorrhage.
6. Polyposis or suspected malignancy.
7. Obstruction.

"Appendicostomy, cecostomy and colostomy as curative measures are, in view of our present knowledge, theoretically unsound and as well ineffectual", so writes Cave[6] in a recent publication.

Recognized procedures are: (1) ileostomy, (2) partial colectomy, and (3) complete colectomy. The Kernig Rutzen Bag is a tremendous help in overcoming the handicap of an ileostomy.

Recently much interest has been aroused in the possibility of vagotomy as another aid in treating this serious problem.

* Read by invitation before the section on Gastro-Enterology at the Annual Meeting of The Medical Society of New Jersey, April 25, 1949.

Regional ileitis or benign nonspecific granulomatous tumor of the bowel was described as any entity by Crohn, Ginsburg and Oppenheimer in 1932. As then described it was confined to the terminal ileum, but today we know it may involve any part of the ileum, jejuneum or colon.

Many of the leading surgeons advocate removal of the diseased area.

In the study of 164 cases Garlock and Crohn found:

Primary resections	Deaths	Recurrence
99 cases	9	19.5%
Short circuiting procedure	Deaths	Recurrence
65	0	13.8%

The balance of favor pointed to the more conservative operation.

Colonic diverticula usually show alteration in bowel function with or without abdominal distress. Commonest symptoms are constipation, diarrhea, flatulence and pain. The clinical picture depends on the degree of inflammation and the nature of any complication.

Acute diverticulitis occurs most commonly in the sigmoid colon. Its complications include perforation of inflamed diverticula (rare) and shock, generalized abdominal pain, and a rigid abdomen.

Most perforations are small and seal off quickly. The region is readily immobilized and protected by layer matting of omentum and intestine. The sigmoid colon tends to migrate posteriorly to the bladder hence the common site for vesicocolic fistula in the lower posterior wall of the bladder.

Chronic diverticulitis is usually accompanied by marked inflammatory hyperplasia with partial intermittent bowel obstruction and adhesions usually found in left lower quadron. The diffentiation between diverticulitis and malignancy is often very difficult in spite of proctosigmoidoscopy and x-ray study. Passage of blood in feces is often associated with diverticular disease.

Diverticulitis with perforation presents another problem. Surgical treatment has been controversial not only concerning indication of operation, but also as to the type of operation advisable. Complications requiring surgery occur most frequently in the sigmoid colon. Laufman classified the complications of diverticulitis requiring surgical management as follows:

1. Acute perforation of the diverticulum.
2. Peridiverticular abscess.
3. Obstruction.
4. Fistula formation.
5. Other disease processes.

CONSIDERATION IN SURGICAL TREATMENT

1. Bowel resection; never in uncomplicated diverticulosis.
2. Operation is avoided in cases responding to conservative treatment.
3. Resection is contra-indicated in presence of active inflammation.
4. Resection is indicated if repeated attacks of diverticulitis have produced narrowed lumen causing varying degrees of obstruction to fecal stream.
5. Colostomy permits a bowel "rest period" after which further treatment is individualized.
6. Resection may have to be done when the physician is unable to exclude malignancy.
7. In rare cases where massive hemorrhage arises in diverticular diseased areas, resection may be advisable.

BENIGN TUMORS OF THE COLON AND RECTUM

No attempt will be made to classify these tumors because of the confusion of names and designation. With the exception of adenomatous polypoid lesions benign tumors of the colon are relatively rare.

Adenoma (polyp) is the most common benign tumor of the intestinal tract. Two-thirds of all intestinal adenoma occur in the rectum. Small or single tumors may be asymptomatic. When large or multiple, frequent bloody mucoid stools may be present. Large pedunculated growth may protrude or cause intussusception as well as obstruction.

Routine sigmoidoscopy usually reveals asymptomatic polyps.

Digital examination may show multiple sessile or pedunculated masses in the ampulla of the rectum. The scope reveals the size, number, extent and character of growth.

Biopsy establishes diagnosis. Polyps should *always* be considered pre-malignant and should be removed immediately. When they are within reach of the scope, fulguration is the meth-

od of choice. If removal is complete, recurrence is rare.

Villous tumor (also called villous adenoma) is rare. Continuous profuse discharge when not explained on the basis of mucous colitis or parasitic infestation should immediately lead one to suspect a villous tumor. This discharge of mucin has been said to reach a total of four quarts daily. It is easy to see how this may be confused with a benign diarrhea. Bleeding tenesmus, pain, and protusion may be present.

Digital and proctoscopic examination plus biopsy assure the diagnosis. *Treatment* includes: fulguration, which, if thorough, gives a good prognosis. Excision of rectum is often done because of the malignant tendency of villous tumors. Manheim[8] believes this is too radical a procedure for a benign tumor.

Polyposis implies multiple papillomata of the colon and rectum. When there are only a few papillomata, they can be removed by colotomy. But when the whole colon and rectum are thickly studded with papillomata, resection of the whole colon (and perphas rectum) may be necessary. Where the papillomata are pedicled, a subtotal colectomy combined with local excision of the papillomata in the rectum may suffice.

MALIGNANT TUMORS OF RECTUM AND COLON

Carcinoids have been, for a long time, mistaken by the pathologist and clinician for carcinomas largely on the basis of pathologic reports. Masson (with special silver stains) showed that these tumors were not epithelial but nervous in origin. They are more frequently encountered in the appendix than anywhere else.

Sarcomata are rare. They extend along the bowel wall rather than into the lumen. Sigmoidoscopy reveals an edematous friable thickened mucosa similar in appearance to the convolutions of the brain. Biopsy establishes the diagnosis. In operable cases, remove the rectum. In inoperable cases, use radiotherapy. Prognosis is poor.

Melanomata are pigment bearing melanotic tumors and rather rare.

Carcinomata: Of the large bowel tumors 95 per cent are adenocarcinomata. From 3 to 5 per cent of rectal cancers are of squamous cell epithelioma type.

The bowel content on the right side is liquid and the tumors tend to penetrate rather than encircle the bowel. Hence obstruction is rare but ulceration is common. In the distal half, the constricting carcinoma occurs frequently, ultimately producing obstruction. A suggestive symptom is any change in bowel habit especially early morning diarrhea. Bleeding suggests cancer and calls for sigmoidoscopy and x-ray study.

Lesions on the right side may produce symptoms of dyspepsia, anemia, melana or fresh blood in the stool. A palpable mass may be present.

Lesions on the left side produce obstruction six times more frequently than on the right side. Here the familiar manifestations are constipation and bright or dark red blood mixed with feces or mucus.

Acute obstruction, while supposedly rare, occurs more frequently than supposed. Partial and progressive obstruction occurs more often than the acute. Pain is not a predominant symptom. Weakness and dehydration often concern the patient more than other symptoms. Bleeding and a mucoid discharge with a characteristic odor are tell-tale symptoms.

AIDS IN DIAGNOSIS

1. Digital examination: About 75 per cent of lesions can be reached this way.
2. Proctosigmoidoscopy.
3. Biopsy.
4. Papanicolaou smear biopsy.
5. X-ray.

COMPLICATIONS

1. Perforation.
2. Fistula formation.
3. Urinary complications.

COMMON ERRORS IN DIAGNOSIS

Malignant tumors of the large bowel are frequently mistakenly treated for hemorrhoids, appendicitis and colitis.

According to Pemberton and Dixon, about 20 to 25 per cent of patients with cancer of the rectum have been subjected to hemorroidectomy within 6 months prior to recognition of the malignant lesion. About 15 per cent of patients with cancer of the right colon undergo

appendectomy at the onset of symptoms (Mayo 1941).

Correct diagnosis requires recognition of lesions and also determination of the presence and extent of distant spread.

Tests such as Vanden Bergh's test, blood phosphates study, et cetera may help in determining liver metastasis.

Prophylactic treatment involves: (1) Cancer awareness of both doctor and patient. (2) Periodic examination especially after 30 years of age. (3) Removal of all benign tumors especially adenomatous polyps.

Worthy of note in considering surgery are these facts:

1. Right sided tumors are often readily resectable.
2. Right sided lesions may be removed even in the presence of marked anemia.
3. From 15 to 20 per cent of successfully resected lesions require the removal in part or whole of some adjacent structure (Cattell)[10].
4. There is no correlation between the size and gross appearance of a node and the presence of metastasis (Gabriel).
5. Metastasis may have taken place to the liver while the local lesion may still be removed.
6. Half of the patients with cancer of the colon or rectum who survive radical resection live for five or more years (Cattell)[10].
7. Malignant tumors of the large bowel are about as frequent as cancer of the stomach. But in the former, the five-year cure rate is at least three times as great (Bockus)[11].

SURGICAL TREATMENT

Rigid standardization of surgical procedure is both impractical and undesirable. We have come a long way from the time of Mathews[2] when the choice of procedure lay most often between an inguinal colotomy and a lumbar colotomy.

The lesions leading to the most controversy in procedure are those located in the left lower bowel. The available procedures are:

1. Combined abdominal perineal resection with permanent abdominal or perineal colostomy.
2. Anterior perineal colostomy with end-to-end anastomosis.
3. Perineal excision or amputation.
4. Palliative colostomy.

Other modes of treatment include:

Surgical diathermy. This is best applied to lesions of the rectum preferably low and posterior. It is used in cases which are not amenable to surgical correction or when surgery is inadvisable.

X-ray therapy and radium have distinct limitations in this field. X-ray therapy is more useful in rectal lesions of Hodgkin's origin.

In pre-operative and postoperative care, the sulfa drugs, penicillin, streptomycin, vitamines, water and N. balance are of untold value. Blood transfusions (particularly during the operation) have proved to be a blessing.

In spite of the controversy over the choice of either drastic removal of lesions or their retention with palliative colostomy, progress certainly is being made. It goes without saying that many results are excellent.

318 Roseville Avenue

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ALLERGY CAN CAUSE BEHAVIOR PROBLEMS

Allergy is a fruitful factor in the making of the problem child, according to a paper delivered by Dr. T. W. Clarke to the American College of Allergists at their 1950 annual meeting. Sometimes the allergy has direct mechanical effects on the nervous system. Sometimes it causes anxious parents to overprotect or invalidize the child. Sometimes it limits the child's recreational and educational activities because of the disability it produces.

TREATMENT OF ESSENTIAL DYSMENORRHEA WITH AN ANTIHISTAMINIC DRUG (PYRIBENZAMINE R HC1*)

David B. Hoffman, M.D., Newark, N. J.

The cause of essential dysmenorrhea has been assigned to psychogenic[1] endocrine[2] and postural[3] factors. Probably all these play some role. Primary dysmenorrhea occurs only with an ovulatory cycle[4] and one of the treatments, temporary though it might be, is to prevent ovulation by the use of estrogens or testosterone.

Smith and Smith[5] were able to demonstrate a "menstrual toxin", recoverable from the menstrual discharge. They showed that this "toxin" was present only in the menstrual discharge during an ovulatory cycle. When the toxin was injected into laboratory animals, the following reactions took place: the urine became concentrated, edema developed in the tissues, vascular damage was noted; and at the site of injection, edema, hemorrhage and necrosis occurred. The same type of response occurs in animals when histamine is injected.[6]

Smith and Smith[5] feel that general premenstrual symptoms, such as headache, nausea and vomiting, result from the reaction to the toxin at points far removed from the site or origin. They consider that the exaggerated local effect of the toxin accounts for the spasm of the primary dysmenorrhea.

The pain of dysmenorrhea is attributable to tetanic contraction of the uterine muscle[7] upon which are superimposed uterine contractions of high amplitude. Novak,[8] quoting Wollner, stated that premenstrually the mucous membrane of the endocervix is greatly swollen. It is conceivable that in a nulliparous woman this is enough to give a relative stenosis of the cervical canal. Thus when menstruation starts, the uterus must contract strongly to overcome the relative stenosis. Once this is accomplished, pain stops or is lessened. This is usually the story in primary dysmenorrhea: severe pain, cramp-like in character, until the flow is definitely established. This can explain also why so many women have been relieved by childbirth[9] or temporarily by dilation and curettement.[10] Much of the pain which is not of cramp-like character is caused by congestion[11] and edema[12] of the pelvic organs.

Asthmatic women have more frequent attacks of asthma during menstruation[13] and especially during the premenstrual period. Frequently, asthma is accompanied by dysmenorrhea.[13] Vignes also finds that some women have a periodic edema[12] during menstruation or a few days preceding it. This may be generalized or preponderant in the feet, hands, face and abdominal cellular tissue.

Considering all the data, I have concluded that edema of the gastro-intestinal tract, the central nervous system, and the genital tract itself, (resulting from liberation of histamine or a histamine-like substance by reaction to the menstrual toxin) causes most of the symptoms. It then seemed to me that an antihistaminic drug might well allay much of the symptomatology associated with essential dysmenorrhea.

Ten patients were observed in private practice ranging in age from 21 to 35. All were examined either rectally, if unmarried, or vaginally, if married. Two patients had one child each, and one had two children. Patient No. 5

* Pyribenzamine (R) HC1 was generously provided by Ciba Pharmaceutical Products, Inc., Summit, N. J.

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was followed for two periods. She became pregnant after this. Patient No. 6 had had an acute salpingitis for which she was operated upon in 1948. All the patients, at the time that the study was undertaken, had negative pelvic findings.

Premenstrually, the treatment consisted of 25 milligrams of pyribenzamine* as soon as symptoms appeared. When dysmenorrhea started, patients were instructed to take one tablet of 50 milligrams three times daily. If no relief was obtained 30 minutes after taking a tablet, the patient could repeat the dose up to a daily maximum of six tablets. Most patients required only 150 milligrams per day. The side reactions consisted of dizziness, sleepiness and nausea. Three patients (Nos. 1, 5, 7) complained of this, but the relief of pain was so satisfactory that they ignored the side reactions. Premenstrual pain in the breast was not relieved by this treatment. However, all were relieved of headaches except No. 10; eight were relieved of backaches premenstrually and all patients were relieved of dysmenorrhea except No. 10. Patient No. 2 complained that menstruation was much more profuse while No. 3 and 4 stated that the menstrual discharge was less.

These results were encouraging enough to prompt a study of the overall effect on such pain in the employees of a large organization in Newark, New Jersey. They were not examined, nor was there opportunity to treat them premenstrually. In this study, there were 76 subjects of whom 22 were married. Their ages ranged from 17 to 45. In the age group of 17 through 25 there were 39 subjects (2 married). Six subjects in this group were unrelieved by medication, and 84.7 per cent were definitely benefited.

Of the 24 subjects in the 26 to 35 year age group, 20 were married. Five subjects were unrelieved and 81 per cent were benefited. There were 13 subjects (all unmarried) in the 35 to 45 year age group. All in this group were benefited.

TABLE 1

Age Range	Subjects	Relieved of Pain	Not Relieved	Ratio of Benefit
17 to 25	39	33	6	85%
26 to 35	24	19	5	81%
36 to 45	13	13	0	100%
All	76	65	11	86%

EFFECTIVENESS OF PYRIBENZAMINE ON PAIN (INDUSTRIAL PATIENTS)

TABLE 2

Before Treatment	Symptom (10 Patients)	After Treatment
	Pain or Discomfort in:	
6	Head	1
7	Breasts	7
5	Back	2
7	Abdomen	3
	Menstruation:	
1	Scant	2
4	Moderate	3
5	Copious	5
10	Painful	1

EFFECTIVENESS OF PYRIBENZAMINE ON SYMPTOMS IN 10 PRIVATE PATIENTS

CONCLUSION

1. A clinical study was undertaken to determine the effect of an antihistaminic drug* upon the symptomatology of dysmenorrhea in a representative group of women selected from private practice (10 patients) and from an industrial payroll (76 patients).

2. a. Dysmenorrhea was relieved in 90 per cent of the private practice group.

b. Dysmenorrhea was relieved in 87 per cent of the industrial group.

3. Relief of premenstrual headache, backache, and abdominal distress was observed in at least 80 per cent of the patients.

4. No effect was observed on premenstrually painful breasts.

5. These findings, while not conclusive, are provocative and it is hoped that this work will be extended.

* Pyribenzamine (R) HCl was generously provided by Ciba Pharmaceutical Products, Inc., Summit, N. J.

31 Lincoln Park

A WARNING ABOUT LENS EXTRACTION IN THE EDENTULOUS PATIENT

Howard P. Snyder, M.D., Elizabeth, N. J.

On September 9, I had planned to do a combined intracapsular extraction on a 51 year old patient who had bilateral central lens changes to the extent that his corrected vision was 20/50 in his right and 20/200 in his left eye. This patient had a progressive dimming of vision in both eyes over a period of one year's observation and finally became unable to carry out his daily work. His physical condition was normal for a man of his age. There were no findings to justify classifying his lens changes as complicated cataracts. This patient had been edentulous for several years and was wearing comfortable dentures.

On September 8, he was admitted to the hospital and received a routine physical examination. He was apparently well-adjusted to the hospital environment. He showed no signs of apprehension. He was brought to the operating room where my assistant and I proceeded with our planned selective operation. After a retrobulbar anesthesia of 1 per cent Procaine was administered, three corneal scleral sutures had been put in position to facilitate the wound closure at the end of the operation. The iridectomy had been performed and the lens had been removed intracapsularly. The lids had been retracted with black silk sutures so as not to cause any pressure on the globe. During the moment after the lens had been delivered and our hands were away from the operative field, the patient's globe bulged simultaneously with his effort at swallowing some saliva. A large amount of vitreous was forced out of the open incision. The wound was immediately closed by tying the already prepared sutures. The iris pillars were in place so no instrumentation was needed. The eye was bandaged and not touched for five days. As a precaution he was given intramuscular penicillin therapy and I was grateful to find that the wound healed uneventfully and that he has good vision today.

This spontaneous loss of vitreous and the bulging of the globe at the moment when no instrumentation was being carried out made me very curious. I asked the patient why he felt that there was pressure at that moment. He told me that whenever his teeth were out, he had great difficulty in swallowing. As a collection of mucus normally gathers, it is not easy to swallow when one has removed his dentures. He had noticed this innumerable times when he was in bed at night. I have since had him remove his dentures and attempted to measure any degree of exophthalmia while swallowing. I could find no perceptible bulging of the eyes. On taking the tension of his globe I found it to be 20.1 millimeters of mercury. When he swallowed with his dentures out, the tension was approximately 23 millimeters of mercury with a Schiotz tonometer with 5.5 weight.

It is a general rule in most hospitals to remove dentures during an operation. I feel that we would be wise in this particular operation to keep them in the patient's mouth and to allow the structures of the face to maintain as normal a position as possible. This will reduce the chance of such a disheartening experience as loss of vitreous which should not be evulsed from an eye of this type. The vitreous appeared normal in composition rather than the more fluid type we find after a pathologic process.

To make this test, an edentulous patient should have some substance resembling the gathering of mucous saliva in the mouth. Honey would be closer as an imitation than water and thus cause more effort in swallowing.

The increase in pressure registers only a momentary shift to the left of the needle and must be noted quickly. This slight increase in pressure is enough to begin the flow of vitreous through the incision.

610 Salem Avenue

STATE ACTIVITIES

M-S PLAN RESOLUTION ON DEATH OF DR. SCOTT

At the meeting of the Board of Trustees of Medical-Surgical Plan of New Jersey, April 25, 1950, the following resolution was passed:

IN MEMORIAM

The Medical Service Administration and the Medical-Surgical Plan of New Jersey have suffered a great loss by the death of Dr. Norman McLean Scott on March 30, 1950. He has been our leader and inspiration since the founding of these organizations. He was a pioneer in the field of finding a solution to the problems of providing medical care through the principle of insurance under the guidance of the medical profession.

His philosophy was always a guiding star in the development of the Medical Service Administration. From that basic organization he labored untiringly to form and later to direct safely the Medical-Surgical Plan which has now become one of the strongest in this special field of service to the people.

His wisdom and counsel in matters pertaining to voluntary insurance were sought far and wide. He was held in high esteem by his fellow workers in The Medical Society of New Jersey and by all those throughout the many States who have been in this vital field of medical care.

He came into the service of The Medical Society of New Jersey in 1938 as an assistant executive officer and in a very short time he was assigned to the project of voluntary insurance plans under the direction of The Medical Society. At the same time he perfectly performed many other assignments and did yeoman's work in cooperation with Doctor Schlichter in directing fairly the important procurement and assignment program for medical officers during World War II.

Dr. Scott was most helpful in our public relations and had an unusual understanding of the problems of the practicing physician. The Medical Service Administration and the Medical-Surgical Plan have been deprived of his fine leadership at a most critical time as we more nearly approach the day when our Plans will be available to all. This complete service, Dr. Scott had devoutly hoped to achieve soon.

The Governors of the Medical Service Administration and the Trustees of the Medical-Surgical Plan have lost a close personal friend for whom we had the greatest respect and affection. He was a man of integrity and was loyal to his ideals and to the profession.

We extend our deepest sympathy to his wife, Mary Hubbard Scott, and their children and we direct that this resolution be spread upon the minutes of Medical-Surgical Plan of New Jersey and proper copy be sent to the family of Dr. Scott.

Further resolved that we request that a copy of our tribute be published in the Journal of The Medical Society of New Jersey and spread upon the records of the Medical Service Administration.

WILL THE PHYSICIAN HELP SOLVE THE PROBLEMS OF ADOPTION?

The practicing physician, perhaps more frequently than anyone else has intimate contact with the mother who is about to be delivered of a child who may later be offered for adoption.

These pregnant women and girls come from homes of a wide variety of economic and social security and culture; many are unmarried and with no certainty as to the paternity of the child; many are married, but the conception is outside of the bonds of matrimony. The teen-age girl is often desperately anxious to keep her condition from her family. At the other extreme, the family may be seeking protection for their child from social stigma but they do not know where to turn for help.

At a recent meeting of the National Catholic Charities Conference in Atlantic City a distinguished member of the clergy reminded social workers that they should remember that physicians, lawyers and the clergy have points of view in relation to adoptions which merited consideration in the handling of the problems which, in practice, have been largely assumed to be the prerogative of the social workers.

The Adoption Council, advisory to the Department of Institutions and Agencies of New Jersey, is vitally concerned that an effort be made to reconcile differences of opinion in relation to adoption practice and ultimately to assure that the services rendered by public and private social agencies shall meet adequately the needs of the child, his mother and the adopting parents.

In May, 1949, Commissioner Bates of our State Department of Institutions and Agencies appointed a Legal Committee to study the State adoption law and to secure the opinions and recommendations of the legal, medical, social work professions and the clergy for amendments to the act which will improve its administration and insure sound social practice. Mr. Alan B. Lowenstein, of Newark, is the chairman of the study committee.

There is today a "grey market" in babies and to a lesser degree a "black market" operating on a commercial basis and without reference to the welfare of the three parties concerned in the transaction.

The social and legal act of adoption in New Jersey as reported by the county surrogates to the Department of Institutions and Agencies has shown an increase from 919 to 1504 in the past five years. Since not all counties reported, it is known that the number must be greater.

Department of Health for 1947 recorded 2436 births out of wedlock in a total of 106,-860 births for that year, during which 1424 adoptions were consummated. One may raise the question as to what disposition was made of those 1012 for whom no legal adoption was accomplished, at least in New Jersey where the demand for children for adoption is very great.

During the war we learned that "team work", (bringing together the skills of the professional disciplines of psychiatry, psychology and social work) accomplished wonders in the solution of problems of rehabilitation. Can we not now "team up" the skills of the physician, the lawyer, the clergy, the psychologist and the social worker for the successful handling of the problems of adoption in the interest of the three parties involved in the adoption process, and in the interest of society as a whole?

Will you, as physicians, help find the solution for these problems by expressing your opinions as to the methods by which our state's adoption law may be made a model of sound social practice? Address your communications and suggestions to Ellen C. Potter, M.D., at 301 West State Street, Trenton 8, N. J. Dr. Potter is the medical consultant to the Legal Committee of the New Jersey Adoption Council.

JEFFERSON CELEBRATES 125th ANNIVERSARY

More than 500 alumni of the Jefferson Medical College are practicing in New Jersey. Nearly all classes are represented from 1875 to the new crop of interns who were graduated in 1950. One of the largest and oldest medical schools in the country, Jefferson was formally opened by Dr. George McClellan in 1825 in Philadelphia, then a city of 138,000; but then, as now, one of the nation's medical centers. One of Dr. McClellan's first acts was to establish an infirmary for the dual purpose of affording medical care to the indigent and providing clinical material for medical students. This dispensary was the first teaching clinic connected with a medical school in the United States. During the years that followed, Jefferson established a reputation for the eminence of its faculty and the practicalness of its teaching. Its star-studded staff included some of the greatest names in world medicine. And, coming down to our own state, the Jefferson Medical College has contributed a great many of the active participants in our society.

The current President of The Medical Society of New Jersey is a Jefferson alumnus. So is Dr. Sica, the chairman of our Board of Trustees, the editor of this Journal and the Councilor from the first district. Four of our Trustees (Drs. Allman, Evans, Sica and Wilentz) are graduates of Jefferson as was Hilton Read, who for so long presided over our Welfare Committee. One of our five A.M.A. delegates is a Jefferson alumnus. And in the 1949-50 year no less than seven of our committee chairmen (Laboratory Medicine, Finance and Budget, Mental Hygiene, Publication, Woman's Auxiliary, Medical Practice and Public Health) were graduates of Jefferson. Our second vice-president, Dr. Henry B. Decker, is a Jefferson alumnus as is the chairman of our Welfare Committee, Dr. Blaugrund. Through the nation at large, more doctors are alumni of Jefferson than of any other medical college in the country. As this grand old school concludes its 125th year, it carries with it the congratulations and good wishes of practitioners throughout the state.

F.A.C.S. OR DIPLOMATE IN SURGERY?

The relative evaluation of a board diploma in surgery compared with Fellowship in the American College of Surgeons has, for some time, been a lively topic for staff-room discussion. The Essex County Medical Society has accumulated some interesting correspondence on the subject. At the request of that society, and in the interest of all concerned, this correspondence is abstracted below. The memorandum from the Essex County Medical Society includes the following explanatory statement.

"This correspondence is of intimate interest to all who devote time and labor to further study in the field of surgery. The letters seem to emphasize three points: (a) The equal status of the Board diploma and A.C.S. Fellowship; (b) The desirability of a merger of the two agencies; (c) The unreasonableness of differentiating between an F.A.C.S. and a surgical board diplomate with respect to privileges and promotions. The correspondence consists of five exhibits as follows:"

Exhibit A. A letter from Dr. Cetrulo to both the A.C.S. and the American Board of Surgery. (June 22, 1949)

Exhibit B. Answer from the American College of Surgeons. (August 12, 1949)

Exhibit C. Answer from the American Board of Surgery. (Sept. 30, 1949)

Exhibit D. Letter from Dr. Beling to the American College of Surgeons. (January 19, 1950)

Exhibit E. Answer to Dr. Beling from the American College of Surgeons. (February 7, 1950)

Note: The letters have been subject to minor editorial condensation. Also, one of the letter writers referred to Board "members" when it was apparent that he meant not members, but "diplomates" or "certificants". A "member" of the Board is one of the senior examiners appointed to that position by one of the sponsoring organizations. A specialist who is certified, becomes a diplomate or certificant; he certainly does not thereby become a *member* of the American Board.

EXHIBIT A. To the American College of Surgeons and to the American Board of Surgery:

Dear Doctor:

For the past several years there has been considerable controversy on the relative merit of membership in the American College of Surgeons as against certification by the American Board of Surgery.

Many of us would appreciate a statement of policy on this issue, that true recognition of the value and standing of A.C.S. membership may not be cast aside, as a result of a distorted sense of values.

Thousands of surgeons are members of the American College of Surgeons, who are not Board diplomates, yet are eminently qualified, as a result of years of training and experience, to cope with the arbitrary standards of the Board of Surgery.

The questions in the minds of these men are as follows and all of us would appreciate some clear cut answers.

1. Should any distinction be made between a Fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, in staff appointments?
2. Are the qualifications of the American College of Surgeons of such standard as to compare favorably with the requirements of the American Board of Surgery?
3. Do army promotions and procurement boards recognize with equal rank, A.C.S. membership and A.B.S. certificate?
4. Is there any policy which states that elevation to Senior Attending in surgical services necessitates certification by the American Board of Surgery?
5. Is there any reason why an attorney should try to make a distinction as to the qualifications of a F.A.C.S. as against a diplomate of the Board?

We feel that a clarification of the above questions and an evaluation of the entire situation will eliminate much of the controversy.

We feel that there should be recognition of quality in the qualifications and requirements of the two groups.

When hospital committees try to follow the policies of the American College of Surgeons in setting up graduate training programs, they invariably turn to requirements of the American Board of Surgery for specific plans.

To ignore this controversial issue will encourage the erroneous belief that future surgeons must be diplomates of the American Board of Surgery to gain recognition, rather than that they should conform to the requirements of the graduate training program of the American College of Surgeons, and thereby attain recognition of their qualifications.

We feel that Fellowship in the A.C.S. or certification by the Board should be recognized with equal status, and, better still, that some common ground of mergence of the two should be established.

Very truly yours,

Gerald I. Cetrulo, M.D.

EXHIBIT B. Answer from the American College of Surgeons:

Dear Doctor Cetrulo:

Direct answers to your five concrete questions present no difficulties, but a more general statement on subjects involving relative merits of different organizations requires judicial consideration if it is to present an accurate appraisal that will be just to all concerned.

1. In making appointments to hospital staffs, there is no reason known to us for differentiating beween the certificants of the American Board of Surgery and Fellows of the American College of Surgeons. The educational standards of the two organizations present no essential differences. Fitness for staff appointments should depend on competence in the case of the patient and conformity to ethical practices.
2. The qualifications required of Fellows of the College at the present time are in no way lower than those of the American Board of Surgery. The Board requires one hundred per cent restriction to practice in the specialty while the College does not emphasize such a degree of restriction in rural areas.
3. The Army and procurement board have in the past placed more emphasis on certification by the American Board of Surgery than on Fellowship in the American College of Surgeons. The reasons for this action are complicated and involve a number of subjects more or less irrelevant to the actual professional merits of the two groups. Energetic action is being taken to correct this discrimination and there are reasons to believe that success will ultimately be attained.
4. We at the College know of no policy that states that elevation to the position of Senior Attending in surgical services necessitates certification by the American Board of Surgery. The American Board of Surgery had disclaimed any such policy in a statement that appears on page 648 of the *Journal of the American Medical Association* of November 6, 1947, Volume 135.
5. There is no conceivable reason why an attorney should appraise or recognize differences between Fellows of the American College of Surgeons and Certificants of the American Board of Surgery.

Sincerely yours,
BOWMAN C. CROWELL,
Associate Director
American College of Surgeons.

EXHIBIT C. Answer from the American Board of Surgery:

Dear Doctor Cetrulo:

In answer to your letter, I shall make no attempt to answer your qestions specifically. But I should like to make the following remarks: The American Board of Surgery was created in accordance with action approved by the Council on Medical Education of the American Medical Association. Primary purpose of the Board has always been to establish and maintain a high standard in the education and training of young surgeons. The Board has and continues to issue certificates of qualification to those surgeons who have met certain educational requirements and who have successfully passed its examinations.

(1) The examination is given in an effort to determine the surgical ability of a candidate.

(2) Evaluation of the educational program from which he may have received this ability. The American Board of Surgery is especially concerned with the educational program and is unwilling to issue certificates on the basis of the examination alone for several reasons: (a) Educators have realized for a long time that no examination yet devised can really test the results of an educational program. This is perhaps the reason that our colleges and universities do not grant degrees on the basis of an examination alone. Candidates for degrees must have completed a prescribed course and, on the completion of such program, are rendered eligible for examination; (b) If a truly dependable examination could be devised, it would afford no evidence as to whether the surgeon examined a given year would really be competent in the years to follow. Self-education of a surgeon has proved to be ineffective in a high percentage of instances; (c) The apprenticeship system to the exclusion of all formal training in surgery is open to many abuses, and the candidate frequently is offered little return for his industry and hard work.

The American Board of Surgery is not concerned with measures that might gain special privileges or recognition for its certificants in the practice of Surgery. *It is neither the intent nor has it been the purpose of the Board to define requirements for membership on the staffs of hospitals.* The prime object of the Board is to pass judgment on the education and training of broadly competent and responsible surgeons—not who shall or shall not perform surgical operations. *The Board specifically disclaims interest in or recognition of differential emoluments that may be based on certification.*

Some of the above information is made available in the Booklet of Information. The sentiments expressed, aside from direct quotations from the booklet, are personal expressions and may not in any way reflect the opinion of this Board and its members.

Sincerely yours,
CLETUS W. SCHWEIGMAN, M.D.,
Assistant Secretary
American Board of Surgery.

EXHIBIT D. From Dr. Beling to the American College of Surgeons:

Dear Doctor:

Your reply to Dr. Cetrulo's letter has been forwarded to me as chairman of the committee on surgery of the Essex County (N.J.) Medical Society. The heart of the problem is expressed in these three questions:

1. Should any distinction be made between a

Fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, in staff appointments?

2. Are the qualifications in the American College of Surgeons of such standard as to compare favorably with the requirements of the American Board of Surgery?

3. Is there any policy which states that elevation to senior attending in surgical services necessitates certification by the American Board of Surgery?

Your answers to these three questions were as follows:

1. In making appointments to hospital staffs, there is no reason known to us for differentiating between the certificants of the American Board of Surgery and Fellows of the American College of Surgeons. The educational standards of the two organizations present no essential differences. Fitness for staff appointments should depend on competence in the case of the patient and conformity to ethical practices.

2. The qualifications required of Fellows of the College at the present time are in no way lower than those of the American Board of Surgery. The Board requires one hundred percent restriction to practice in the specialty while the College does not emphasize such a degree of restriction in rural areas.

3. We at the College know of no policy that states that elevation to the position of Senior Attending in surgical service necessitates certification by the American Board of Surgery. The American Board of Surgery has disclaimed any such policy in a statement that appears on page 648 of the *Journal of the American Medical Association* of November 6, 1947, Volume 135.

Keeping the above questions and answers in mind, as well as the other contents of the two letters, will you please give me the College's answers to the following, as they apply to Newark, New Jersey, a city of over 400,000 persons:

1. You have stated that "The qualifications required of Fellows of the College are in no way lower than those of the American Board of Surgery". For how long has this been true?

2. Some men, who neglected to apply for Fellowship some years ago, but who have the same or similar qualifications required of others of the same age group who became Fellows, have applied for Fellowship within the past two years and have been informed that their qualifications were not sufficient for consideration. Do you think that those who obtained Fellowship at that time, and who have not taken additional training are to be considered superior to those of the same age group with the same qualifications but who are now unable to obtain Fellowship?

3. Do you think that men who obtained Fellowship prior to the date which you give in answer to Question 1, and who have not had additional training acceptable under your present standards, are likely to be as well qualified surgically as those admitted to Fellowship under the newer requirements which are similar to those of the American Board of Surgery? Are they as likely to be as well qualified as a diplomate of the American Board of Surgery?

4. If the answers to question 3 are No, will you please state why. If the answers are Yes, why have the requirements for Fellowship been increased to the point where they are similar to those of the American Board of Surgery?

5. Is it not true that, for Fellowship at the present time, a surgeon's training must be such that he may easily qualify for the examinations of the American Board of Surgery?

6. If an applicant for Fellowship is a diplomate of the American Board of Surgery and meets the requirements of the College is the writing of case reports ever waived either wholly or in part?

7. What degree of specialization does the College require of Fellows in this metropolitan locality?

C. A. Beling, M.D.

EXHIBIT E. Answer of American College of Surgeons to Dr. Beling:

Dear Doctor Beling:

It is my feeling that the situation was adequately covered in the correspondence between Dr. Crowell and Dr. Cetrulo; but in brief will state in reply to your queries that:

1. It is our belief that the over-all requirements for Fellowship have always been equivalent to or superior to the requirements for the various specialty boards.
2. We are not in a position to judge the qualifications of those who have never submitted their credentials for evaluation.
3. This question does not lend itself to a categorical answer as you must realize that surgeons are human beings—some continue to study and advance themselves and others show little progress.
4. The increased complexity of knowledge necessary to succeed in modern surgery has made it necessary to increase the amount of time allowed to the proper training of all qualified surgeons.
5. The College and the various specialty boards practically all have independent methods of evaluating the credentials of applicants so some who are considered to be qualified by the boards are not so considered by the College, and *vice-versa*.
6. The requirements concerning written case records is sometimes waived for applicants who have been certified by the specialty boards if their training and other credentials are entirely acceptable to the College.
7. The degree of specialization in any community should be determined by the needs of the community.

Sincerely yours,

H. P. Saunders, M.D.,
Associate Director
American College of Surgeons

ESSEX COUNTY SERVICE FOR THE CHRONICALLY ILL, INC.

William H. Hahn, M.D., President

What is happening to our chronic ill? What is going to happen to them? These questions have long concerned everyone interested in health problems. The problem of the care of the chronically ill is rapidly becoming larger with our increasing life span, and threatens to overwhelm us.

The Essex County Service for the Chronically Ill, organized in 1948, at the suggestion of the Essex County Medical Society and the Newark Welfare Council, has as its purpose the development of an adequate program for the care of the chronically ill in Essex County. The problem is complex, involving economic, social and other factors, as well as health. The full force of all agencies concerned with the various factors must be directed toward its solution. To that end this organization has been pleased to have the support and cooperation of the doctors, dentists, nurses, welfare and social workers, hospital representatives and representatives of municipal and county government. The organizations representing these various professions and agencies now cooperate in their efforts through the Essex County Service for the Chronically Ill.

Financial support has been afforded by the Essex County Chapter (N. J. Div.) of the American Cancer Society, the Essex County Chapter of the National Foundation for Infantile Paralysis, the New Jersey Chapter of the National Society for Crippled Children and Adults, the New Jersey Heart Association, the Friendly Sisters and others. A membership roll is now being compiled to enlist the interest and support of all interested organizations and individuals.

The Service has developed as a study, informational and referral service, as well as an advisory body, leaving the implementation of the program to existing agencies. A survey of the chronically ill of Essex County has been instituted and a compilation of the facilities for their care has been completed.

Prevention, care and rehabilitation are all phases of a program for the care of the chronically ill. Health maintenance centers, recently proposed by the Essex County Medical Society, should aid materially in preventing chronic illness through early detection. Home care is of great importance and we are trying to aid the development of a home care program, including homemaker service, in each community. Institutional care will be simplified through the development of this program. It is hoped that municipal and county aid will be forthcoming. Rehabilitation, too, is being developed in Essex County.

Enthusiasm, ability, and willingness to work have characterized all those who have lent their efforts to the development of this service. We hope that our membership roll will be used by many more as an opportunity to aid in the solution of the problem of the care of the chronically ill. The cooperation of all will permit an effective and complete program.

COURSE IN CEREBRAL PALSY

The Cook County Graduate School of Medicine, announces a two week intensive orientation course in cerebral palsy to be conducted by Dr. M. A. Perlstein, beginning July 31, 1950. The course is designed for doctors and includes lectures, demonstrations, clinics and discussion periods to acquaint students with the latest knowledge on the causes of cerebral palsy and the newest treatment technics.

The summer cerebral palsy course will have a limited enrollment, so it is important that applications be sent in early. Fee for the course is $150, of which $25 is payable on registration.

Further information may be obtained from Cook County Graduate School of Medicine, 427 South Honore St., Chicago 12, Illinois.

SOUTH JERSEY ENT VACANCY

The Camden office of the Veterans Administration announces a vacancy for a part time physician qualified in ear, nose and throat work. Interested applicants should communicate with the Senior Medical Officer, Dr. William C. Wells, VA Office, 300 Broadway, Camden. The telephone number is Woodlawn 4, 8757.

SUPPLEMENTARY LIST No. 3 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Achtentuch, Herman, 113 Sherman st., Passaic (16)
Adler, Joseph, 933 Avenue C, Bayonne (9)
Alter, Nicholas M., 410 Fairmount av., Jer. City (9)
Ashley, Harmon H., 20 Nassau st., Princeton (11)
Barton, Amy S., 509 Chester av., Moorestown (3)
Bassett, Samuel, 355 Washington av., Dumont (2)
Belfer, Jacob J., 1235 Chambers st., Trenton (11)
Bennett, Robert E., N. J. State Hosp., Trenton (11)
Beyer, Othmar J.. 42 Laurel av., Irvington (7)
Bitten, Robert M., 11 Romaine av., Jersey City (9)
Blanchard, Charles L., 28 E. Blackwell st., Dover(14)
Blum, Milton, 41 Tonnele av., Jersey City (9)
Bono, Joseph J., 631 Anderson av., Cliffside Park(2)
Borino, John W., Jr., 15 Washington av., New'k(7)
Broselow, Benjamin G., Delsea dr., Franklinville(8)
Brundage, Robert H., 232 Ivy ct., Orange (7)
Buford, Charles C., Jr., 507 S.Warren st.,Trenton(11)
Cherashore, Harry N., 363 Centre st., Nutley (7)
Connor, Clarence A., 1586 Center av., Fort Lee (2)
Davis, John E., Jr., 211 Linden st., Riverton (11)
Della Fera, Lucien F., 206 First av., Newark (7)
Dempsey, J. Harvey, 66 Washington av., Berlin (4)
Dodge, James T., 1819 S. Broad st., Trenton (11)
Eulner, Elmer H., 216 Henry st., South Amboy (12)
Fauquier, Leonard B., 172 Jewett av., Jersey City(9)
Fechner, Fred J., 846 Garrison av., Teaneck (2)
Fechner, Herta, 846 Garrison av., Teaneck (2)
Feeney, Edward, 156 Pompton Tpk.,Pequannock(16)
Feldman, Matthew, 120 Bogert rd., N. Hackens'k(2)
Fister, Harris G., 210 W. Main st., Maple Shade (3)
Flax, Ira I., 890 S. 16th st., Newark (7)
Frisch, Felix, 726 West State st., Trenton (11)
Garrett, Thomas A., 315 Park st., Hackensack (2)
Gatto, Isaac N., 60 Arcadia rd., Hackensack (2)
Gibbins, A. Leslie, 60 Roseville av., Newark (7)
Gilligan, Walter W., 164 Forest av., Glen Ridge (7)
Gilmour, John R., 144 Harrison st., E. Orange (7)
Gross, Robert J., Knollcraft rd., Lyons (18)
Grunberg, Albert, 18 S. Munn av., E. Orange (7)
Haggerty, Francis F., 724 Hudson st., Hoboken (9)
Hale, Matthew J., 467 High st., Burlington (3)
Harrington, Walter L., 104 S. Munn av.,E.Orange(7)
Hernandez, Manuel, 1974 Boulevard, Jersey City (9)
Hersh, David H., Navy (7)
Higgins, Thomas F., 224 Monmouth rd., Elizab'h(20)
Horowitz, Robert, 2769 Boulevard, Jersey City (9)
Hurewitz, Benjamin, 0-95 Midland av., F. Lawn(16)
Ingling, Harry W., 51 West Main st., Freehold (13)
Ivins, William C., 455 West State st., Trenton (11)
Johnson, Winton H., 210 Main st., Hackensack (2)
Johnston, Julian F., 21 VanDoren av., Chatham (14)
Kandle, Roscoe P., 20 Edgemere av., Trenton (11)
Kanning, Frederick R.,57 W.Allendale av.,All'nd'e(2)
Kaplan, S. Bernard, 31 Lincoln Pk., Newark (7)
Katzenbach, C. Buckman, 415W.State st.,Trent'n(11)
Keller, Rudolph J., 821 Garden st., Hoboken (9)
Kerdasha, George S., 135 79th st., N. Bergen (9)
Kessler, Edward I.,N.J. State Hosp.,Greystone P.(14)
Kimmich, John, Campbell Soup Comp'y, Camden (4)
Kossmann, Walter J., Long Valley (14)
Kuhn, Richard E., 39 Fernwood ct., Clifton (16)
Lee, Frederick P., 155-A River dr., E. Paterson(16)
Leone, Armando, 416 Park av., Paterson (16)
Lewis, Albert, 41 Retford av., Cranford (20)
Lewis, Sanford M., 39 Meadowbrook pl.,Maplew'd(7)
Liberl, Ercole J., 317 Clements Br. rd., Barr'gt'n(4)
Light, Arthur B.,Lawrenceville Sch'l,Lawr'cev'e(11)
Linke, James J. P., 245 E. Front st., Plainfield (20)
Lorentz, Emma B., 94 Grove st., Somerville (18)
Luksteid, Casimir J., 326 Park av., Paterson (16)
MacDonnell, Martin J., 40 74th st., N. Bergen (9)
Magee, Harold S., N. J. State Hosp., Trenton (11)
Mangelsdorff, Arthur F., 707 W. 8th st.,Plainfield(18)
Mara, Francis J., 452 Wayne st., Jersey City (9)
Marano, Michael A., 2009 Palisade av.,Union City(9)
Massey, J. Bruce, 665 High st., Newark (7)
Minschwaner, George G., Jr., 832 Greenwood av., Trenton (11)
Murphy, Arthur G., 454 Park st., Up. Montclair (7)
Olson, Vendela E., 308 Union st., Hackensack (2)
O'Neill, Earl A., 503 Park av., Plainfield (20)
Preece, John D., 192 West State st., Trenton (11)
Proudfoot, Perry A., 527 Walnut st., Roselle (20)
Read, Donald B., 105 Hudson st., Jersey City (9)
Regan, Cornelius J., Cooper Hospital, Camden (4)
Santor, G. Frank, 3176 Westfield av., Camden (4)
Scala, H. Albert, 212 Garfield av., Jersey City (9)
Scudese, Vincent A., 440 Parker st., Newark (7)
Smith, Percy L., W. Afton av., Yardley, Pa. (11)
Stabile, John A., Grand av., West Trenton (11)
Taft, Herman L., 4401 Boulevard, North Bergen (9)
Wagner, John, 48 Wilson av., Newark (7)
Williams, Paul T., 626 Perry st., Trenton (11)
Zuckerman, Ruth, 309 Johnson av., Teaneck (2)

ASSOCIATES

Buckler, Arthur S., 751 High st., Newark (7)
Lake, George, 162 Clinton pl., Newark (7)
Staub, Robert J., 10 Park rd., Short Hills (7)

OBITUARIES

DR. HARRY B. BOSSARD

Dr. Harry B. Bossard died of a heart attack at his home near Harmony on April 12, 1950.

Born in Martins Creek in 1878, Dr. Bossard attended school in Easton, Pa., and was graduated from Jefferson Medical College in 1901. Following internship in Easton Hospital, Dr. Bossard set up offices in his home near Harmony.

Dr. Bossard was a member of the staff of Warren Hospital and had served as treasurer and president of the Warren County Medical Society. At the time of his death he was medical examiner for schools of Harmony and Hopatcong Townships, and for the past 43 years he was medical examiner for the Prudential Insurance Co.

DR. PELLEGRINO A. D'ACIERNO

Dr. Pellagrino A. D'Acierno of Union City died of a heart attack on March 2, 1950.

Born in Naples, Italy, in 1881, Dr. D'Acierno came to the United States many years ago and had been a resident of Union City for 40 years. He was graduated from the Royal University of Naples with an M.D. degree in 1906. He was formerly in charge of obstetrics and gynecology at North Hudson Hospital, and assistant obstetrician at the Margaret Hague Maternity Hospital. He had been a fellow of the American College of Surgeons since 1933 and a diplomate of the American Board of Obstetrics and Gynecology since 1935. He served in the U. S. Army Medical Corps in World War I. In 1949 Dr. D'Acierno won acclaim by being given a place in "Important American Poets and Songwriters" for his books "Scattered Leaves" and "Juvenile". Dr. D'Acierno was immediate past president of the Hudson County Medical Society.

DR. JAMES T. HANAN

Dr. James T. Hanan, former Montclair Town Commissioner, died on April 24, 1950, at his home in Montclair.

Dr. Hanan was born in Brooklyn in 1876 and received his medical degree from Columbia College of Physicians and Surgeons in 1899, after which he did postgraduate work in England, France and Germany. He joined the staff of Mountainside Hospital in 1914 and was named surgeon emeritus in 1937. He served in the Navy in World War I and was active in the medical work of civilian defense and emergency medical services in World War II.

Dr. Hanan was a Fellow of the American College of Surgeons and held membership in several local civic organizations. He was intensely interested in art and frequently exhibited paintings at the Montclair Art Museum and other galleries.

DR. EDMUND W. ILL

Dr. Edmund W. Ill of Newark, died of a heart attack at St. Barnabas Hospital on April 2, 1950.

Dr. Ill was born in Newark in 1891, a son of the late Dr. Charles L. Ill, and a nephew of the late Dr. Edward J. Ill, noted New Jersey physician. Dr. Ill represented the third generation of his family in the practice of medicine in Newark. He was graduated from Princeton University in 1913 and received his medical degree from the College of Physicians and Surgeons of Columbia University in 1917. He then served two years in the Army Medical Corps in France during World War I.

Dr. Ill was long active in relief work in Newark, and in 1933 was appointed deputy municipal director in charge of health and sanitation in Newark of the State Emergency Relief Administration. He was a Fellow of the American College of Surgeons, a staff member of St. Michael's Hospital, former staff president and staff member at St. Barnabas.

DR. JOHN A. KENNEY

Dr. John A. Kenney, one of the most distinguished Negro physicians in the country, died in Montclair on January 30, 1950.

John Kenney was born in Virginia in 1874 and was graduated from medical school in 1901. During his lifetime he served as personal physician to Booker T. Washington and to George Washington Carver. He was medical director of the Memorial Hospital at Tuskegee, Alabama, for a long period and came to New Jersey in 1932 when the Ku Klux Klan threatened his life because of his insistence that Negro physicians be accepted on the staff of the Veterans Hospital in Alabama. Shortly after coming to Newark he established the Community Hospital, New Jersey's only Negro-staffed institution and subsequently turned that hospital over to a non-profit association representing the Negro population of New Jersey.

Dr. Kenney was active in the National Medical Association and served as president of that group in 1912. He was widely known for his work in the field of medical journalism and founded the Journal of the National Medical Association, which he edited for many years. Some years ago he won the award of the Harmon Foundation as the most prominent Negro American of the year.

DR. CHARLES H. KNAUER

Dr. Charles H. Knauer, chief of staff at Trenton General Hospital, died on March 22, 1950, in the midst of an operation at the hospital.

Dr. Knauer was born in 1896. He was graduated from the University of Pennsylvania Medical School in 1920 and began his practice at Tamaqua, Pa., where he was resident physician at the Schuylkill County Alms House Hospital. Later he practiced in Mahanoy City, Pa., and was school doctor for Mahanoy Township as well as staff physician at Locust Mountain Hospital.

In 1939 Dr. Knauer opened an office in Trenton as an eye, ear, nose and throat specialist. He had been on the staff at Trenton General Hospital since 1940, and also did eye work at the State Hospital.

DR. BURR W. MACFARLAND

Dr. Burr W. MacFarland, Trenton, died on February 23, 1950, after a lengthy illness.

Dr. MacFarland was born in Mount Holly in 1867. After attending the Philadelphia College of Pharmacy he entered Jefferson Medical College and received his medical degree in 1888. He served his internship at Cooper Hospital, Camden. Dr. MacFarland practiced in Bordentown for ten years, and came to Trenton in 1900 as a specialist in eye, ear, nose and throat diseases. Since 1910, he had devoted his practice exclusively to the treatment of eyes.

Dr. MacFarland was a member of the staff of Wills Eye Hospital, Philadelphia. He was an honorary member of the Mercer County Medical Society and an emeritus member of The Medical Society of New Jersey. Last year he received a 50-year gold service button from the Jefferson Medical College.

DR. BENJAMIN OLDER

Dr. Benjamin Older, a retired Union City physician, died on April 19, 1950, in St. Petersburg, Fla.

Dr. Older, who was born in New York City in 1883, was graduated from the College of Physicians and Surgeons in Boston in 1906, and shortly afterward established his practice in West Hoboken. He served as town physician for four years and was one of the founders of North Hudson Jewish Community Center. For a number of years he was chief examining physician for the Prudential Life Insurance Co. in the Union City area. He was on the courtesy staff of St. Mary's Hospital, Hoboken, for 15 years. Dr. Older was an Emeritus Member of the Hudson County Medical Society and The Medical Society of New Jersey.

DR. NORMAN M. SCOTT

The Medical Society of New Jersey lost one of its most devoted and effective workers on March 30, 1950, with the death on that day of Dr. Norman M. Scott.* Born in Hyde Park, Massachusetts in 1889, Dr. Scott received his M.D. degree from Tufts in 1911. His original professional interest was in obstetrics and gynecology, and he served residencies in those specialties at the Carney Hospital in Boston and at the Lying-In Hospital in New York. He practiced privately in Boston in 1915 and 1916, and the following year obtained a commission in the U. S. Army. He served with combat troops in World War I and was assigned in the Regular Army as attending surgeon for the Paris area during a brief period following the armistice. He received a citation from General Pershing at the conclusion of his foreign service in 1919.

Dr. Scott remained in the Army, serving in various stations throughout the world, reaching the grade of lieutenant colonel at the time of his retirement from the Army in 1938. That year he entered the service of The Medical Society of New Jersey, first as executive assistant to Dr. Wilkes, later as director of medical care programs. Dr. Scott acquired a mastery of the actuarial, professional and administrative aspects of health insurance which led to nationwide recognition in this field and he was medical director of the Medical-Surgical Plan at the time of his death.

DR. CLARENCE J. SLACK

Dr. Clarence J. Slack, Trenton, died on April 25, 1950, at the age of 68.

Dr. Slack was graduated from Medico-Chirurgical College of Philadelphia in 1905 and had practiced in Trenton for more than 40 years. He was a veteran of World War I, and was a member of the staff at Mercer Hospital, Trenton, since 1906, retiring as surgical chief in 1948.

DR. JOHN S. YATES

Dr. John S. Yates, a practicing physician in Paterson for the past 50 years, died on March 18, 1950.

Dr. Yates was born in Manchester, England, in 1867 and came to this country at the age of 15. He was graduated from the Medico-Chirurgical College in 1898 and interned at St. Joseph's Hospital, Paterson. He was a past president of the Passaic County Medical Society.

CALLING ALL PENNSYLVANIA MEDICAL ALUMNI

The Medical Alumni Society of the University of Pennsylvania will hold medical and surgical clinics at the University Hospital from 9:30 to 11:30 a. m. on Alumni Day, June 17.

Following the clinics, the Society will hold a luncheon at noon at the Penn-Sheraton Hotel, 3900 Chestnut Street.

For further information communicate with the Executive Secretary, Medical Alumni Society, at the School of Medicine.

PRIZE AWARD TO DR. FERNICOLA

Dr. Anthony Fernicola, resident in urology at the Newark City Hospital, won the first prize in the essay contest of the New York Branch of American Urological Association. This contest was open to all urologic residents in the metropolitan area. Title of the prize-winning paper was "Extra-Urethral Confines of Urethrographic Contrast Medium". He presented this essay at the meeting of the New York Branch on April 19, 1950.

*For editorial comment on the death of Dr. Scott, see page 140 of the April JOURNAL.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Recommendations which may affect the development of local public health administration are now in the process of crystallization by the Committee on Local Health Administration appointed by Governor Driscoll in March.

In appointing the Committee, Governor Driscoll said:

"Provision for basic local public health services for all the people, whether in city, town or rural areas has been recognized as an urgent need in New Jersey for many years. It is a problem which has been studied and restudied by health officials, health agencies, citizen groups, and interested persons during the last twenty-five years. Based upon these studies, various proposals have been offered. While these proposals have varied in many ways, all have been based on the principle of building the local health unit on a population large enough to support and use fulltime services.

"I have appointed the Governor's Committee on Local Health Administration to reappraise these studies objectively, mindful of our present situation, and to recommend specific steps which should be taken, including such legislation as may be required, to secure for all the people of New Jersey the type of local health services which is their due."

Members of the Committee include the following: Mrs. Gloanna MacCarthy, Maplewood, former member of the Assembly, chairman; Senator Samuel L. Bodine, Flemington; Senator Anthony J. Cafiero, Wildwood; Senator W. Howard Sharp, Vineland; Assemblyman C. William Haines, Masonville; Assemblyman Emmert R. Wilson, Stockton; Assemblyman Edwin J. Snediker, New Brunswick; Dr. Joseph E. McLean, Princeton University; Dr. Samuel Blaugrund, Trenton, representing the Committee on Public Health of The Medical Society of New Jersey; Mrs. J. Brogley, New Brunswick; Mayor Fred W. Chapman, Somers Point; Mayor John F. Fitzpatrick, South River; Mrs. F. W. Hopkins, Highland Park, president of the League of Women Voters of New Jersey; Dr. Roscoe P. Kandle, Trenton; George Kavner, Paterson, executive secretary, Passaic County Tuberculosis and Health Association; William T. Ludlum, Glen Rock, president, Association of Chosen Freeholders of New Jersey; Mrs. L. Mancusi-Ungaro, Newark; Mrs. Archibald Murray, Summit; Frank Osborne, Health Officer, East Orange; George S. Pfaus, East Orange; Dr. Bennett M. Rich, political science department, Rutgers University; Dennis Sullivan, Health Officer, Jersey City; Lloyd B. Wescott, Clinton; Charles F. Krause, Commissioner of Water and Light, Weehawken; Joseph J. Jialdini, Commissioner, North Bergen.

The Committee has held several meetings and has studied available public health facilities in New Jersey in relation to the need, and efforts in this and other states to achieve more effective local public health administration. It has received the views of many organizations and has heard presentations by specialists affiliated with the State Department of Health, the U. S. Public Health Service, the American Public Health Association, the National Municipal League, and others. It has reviewed and is continuing to review voluminous material from various sources on local public health administration. The Committee expects to put out an interim report this month.

CAMP PHYSICIAN WANTED

The Boy Scout Council in the Newark area needs a physician to live in their camp at Blairstown, N. J., during the summer of 1950. Any doctor interested in obtaining a summer vacation under these circumstances may secure further details by writing to the Camp Director, Boy Scouts of America, 31 Central Avenue, Newark, N. J.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, March 10, with Dr. M. Browne Holoman, presiding.

Edward O. Harper, M.D., assistant professor of Psychiatry at Western Reserve University, University Hospital, Cleveland, Ohio, was the guest speaker. His subject was "Psychosomatic Concepts in Modern Medicine". This increasingly important phase of present day medicine was thoroughly discussed in Dr. Harper's interesting and fine presentation.

It was brought to the attention of the Society that a special professional liability contract was available, protecting the Society and its officers against damages arising from claims or suits for alleged slander, libel, or defamation of character or professional ethics. The contract is issued by the United States Fidelity and Guaranty Company. After favorable discussion, it was voted that the Society purchase such a policy giving protection in the amounts of $15,000 to $45,000 at an annual premium of $36.60.

Dr. Nickman announced that a total of 95 per cent of members have paid the 1949 A.M.A. assessment. This fine record places this Society high among the leaders of the various societies in the state. Dr. Holoman praised Dr. Nickman for his excellent and diligent efforts.

Dr. Shavelson reported only fair progress in the current 1950 Heart Campaign. He stated that probably only half the goal of $25,000 will be reached, that only 16 per cent of Medical Society members had contributed, and earnestly requested more substantial support of this worthy cause.

Our own annual meeting, usually held after the State meeting, this year will come before it. In order not to unduly complicate matters in regard to delegates and the State assessment, it was voted that the present elected officers and committees retain their positions until June 1.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular monthly meeting of the *Burlington County Medical Society* was held on April 13 at the Riverton Country Club. President E. V. Davis opened the meeting at 9:15 p. m.

The business portion of the meeting was short but the following bear mention:

1. The uniform isolation period of two weeks for all poliomyelitis cases in the county was adopted.
2. The Forum on Cancer was held on April 14 at Burlington High School, at 8:00 p. m. Dr. William Bray served as moderator.
3. The May meeting is to be the regular Ladies' Night. The program committee is planning something entirely different for this year.

The scientific part of the program consisted of case reports by members of the county, as follows:

1. Barbiturate Poisoning—Dr. Bruce Dickson
   Discussion by Dr. Arthur Peacock.
2. Sarcoidosis—Dr. William Betsch
   Discussion by Dr. Perry MacNeal.
3. Experiences with Intravenous Procaine—
   Dr. Winfield Betts
   Discussion by Dr. Vernon Davis.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held in the Dispensary Building at 9:00 p. m., April 4, with President A. M. K. Maldeis presiding.

Mr. Jack Marks, president of the Camden County Pharmaceutical Society, was introduced to the society and expressed his appreciation for being invited to the meeting and stated that he hoped that the two societies would be able to meet together some day as they were very anxious to cooperate with the medical profession in every way possible.

Dr. Barnshaw announced that the annual outing of the Society would be held at the Tavistock Country Club on May 18. Drs. Greenhart and Shaw were appointed to take care of the golf program.

The president announced that nurse recruitment should be encouraged, and that the Southern Branch of the Industrial Nurses Association invited the members of the Society to attend a meeting in April to hear Dr. Norton speak on socialized medicine in relationship to nursing. Another announcement referred to the availability of medical officer appointments by the U. S. Civil Service Commission.

Drs. Joseph Costanzo, Joseph Liberi, and Thomas Pastras were introduced to the Society after taking the oath of membership and signing the roll book.

The Society had the privilege of having one of the country's foremost thoracic surgeons as the speaker for the evening, Dr. Charles P. Bailey, associate professor of Surgery of the Hahnemann Medical College and Hospital. Dr. Bailey presented a paper on the *Treatment of Cirrhosis of the Liver by Actual Porto-caval Anastomosis.* The causes, results and medical treatment were discussed as well as the surgical technic of the porto-caval anastomosis through a thoraco-abdominal approach and its many advantages stressed. A series of 15 cases was presented and pictures of the operation shown. Numbered among the doctors who asked questions and discussed the paper were Drs. Sharp, Gamon, H. Eynon, Jack, McDermott, Corieli, Milnamow, and Delbert.

ESSEX COUNTY

Frank S. Forte, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held on March 9, at the Academy of Medicine, Newark. This was a special occasion in view of the fact that the members of the

Woman's Auxiliary, joined us in a combined meeting.

Our president, DR. JOSEPH I. ECHIKSON, opened the meeting and when the Society business was completed he then presented DR. CHARLES S. CAMERON the speaker of the evening, whose topic was "Cancer—A Personal Problem". He reviewed various phases of the problem covering a forty year period. In addition to his many accomplishments the speaker has the distinction of being Medical and Scientific Director of the American Cancer Society. The presentation was very well received.

Of special interest is the "Atomic Information Week", which the Essex County Medical Society, in cooperation with the City of Newark, will present on Monday evening, March 27, at 8:45 p. m., at the Academy of Medicine.

The Essex County Doctors' Male Chorus have announced a concert on the evening of Wednesday, April 15, at the auditorium of the Mutual Benefit Life Insurance Company, 300 Broadway, Newark. This chorus composed entirely of Essex County physicians enjoys a national as well as state reputation. True to the doctor's tradition of helping worthy causes this choral group plans to turn over the proceeds of the concert to the Essex County Service for the Chronically ill.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

With J. PAUL BURKETT, M.D., in the chair, the *Gloucester County Medical Society* met at the Woodbury Country Club, March 16, 1950. ELMER L. GRIMES, M.D., of Woodbury was elected to full membership in the society. It was decided to insure the society and its officers against suit for libel, slander, etc., coverage to be $25,000 to $75,000.

Wendell Burkett, M.D., and I. N. Patterson, M.D., reported for the Legislative Committee. Dr. Burkett suggested that a letter of commendation, approval, and cooperation be written to the State Society concerning their Twelve Point Program.

There was considerable discussion about various physicians in industry in the county treating patients and referring them to specialists without consulting the family physician. This matter was referred to the Public Relations Committee for further study and appropriate recommendations.

The scientific program consisted of an excellent paper "Cardiology for the General Practitioner" given by SAMUEL BELLET, M.D., cardiologist at the University of Pennsylvania. This address was very timely and instructive and aroused many questions which were ably answered. Many more members were present at this meeting; it is hoped that the attendance will continue to improve.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held the sixth regular monthly meeting of the current season on March 7, at Murdoch Hall, Jersey City Medical Center. DR. VINCENT P. BUTLER presided.

Dr. Ginsberg, chairman, Committee on Postgraduate Medical Education, reported that the four courses now in progress are self-supporting. It is the aim of the committee to maintain this policy in future courses. Inquiry among members participating in the postgraduate work has elicited most favorable comment. The committee is planning a second section on *Surgical Anatomy* for the early fall—about October 1, 1950. There will be a meeting of the Committee in the near future to arrange for new courses for the fall season.

Committee on Constitution and By-Laws, under the chairmanship of Dr. Ruoff, reported that the work of revising the 1935 edition of the Constitution and By-Laws continues. Since the committee desires to have the revised edition represent the wishes of the membership at large, as well as conform to the highest standards of organizational procedure, any member, upon request, may have a mimeographed copy of the Constitution and By-Laws, to be used as the basis of his suggestions.

Dr. Meyerson, chairman, Annual Dinner Committee of 1950, reports that this committee is progressing with enthusiasm, to the end that a thoroughly enjoyable evening is assured those who attend the Annual Dinner on April 15, 1950, at The Biltmore, New York City.

Dr. Evans, chairman, Nominating Committee, reports nomination of *President,* NOAH MEYERSON; *Vice-President,* WILLIAM J. GLEESON; *Secretary,* JOSEPH P. DONNELLY; *Treasurer,* ANTHONY J. CONTY; *Reporter,* HARRY J. PERLBERG, for the year 1950-51.

The following members were nominated to serve for a period of three years to 1953: Board of Trustees—HAROLD SAGER and ELLIS J. CHAPMAN; to complete the unexpired term of Hugh H. Tyndall (resigned), LOUIS L. PERKEL; Board of Censors—J. L. EVANS; Audit Committee—FRANK R. ARNDT; Publication Committee—RAYMOND S. DRISCOLL, CHARLES L. QUAGLIERI, NATHAN L. SHULMAN, EDWARD SALMON; Committee on Constitution and By-Laws—SAMUEL I. KOOPERSTEIN; Legislative Committee—S. G. SCOTT, JOHN J. DANIELSON, EMMET J. CONNELL; Maternal Welfare Committee—HERMAN B. KAPLAN, E. G. WATERS, A. C. LARGAY; to complete unexpired term of P. A. D'Acierno (deceased), LOUIS A. SCHNEIDER.

The following were nominated to serve for one year (1951): Delegate to State Nominating Committee—JAMES F. NORTON; Alternate Delegate to State Nominating Committee—J. LAWRENCE EVANS; Election Committee—SAMUEL G. SCOTT, LOUIS A. SCHNEIDER, JAMES A. MCCARRON, JOHN C. TALTY, WILLIAM M. DOODY, SAMUEL SCHEFT, JOHN J. DANIELSON.

DR. IRVING SCHULMAN of Jersey City was elected to membership.

At the close of the Executive Session, Dr. Butler paid tribute to our immediate past president, the late DR. PELLEGRINO A. D'ACIERNO, who died suddenly on March 2, 1950, while attending a patient in his office. Standing, the Society observed a moment of silence in his memory.

DR. PAUL H. HOLINGER, associate professor of Broncho-Esophagology, University of Illinois College of Medicine; attending Broncho-Esophagologist at The Children's Memorial Hospital and St. Luke's Hospital, Chicago, Illinois, was the guest speaker. Dr. Holinger's subject was *The Clinical Significance of Bronchial Obstruction* (Illustrated).

MIDDLESEX COUNTY

Martha F. Leonard, M.D., Reporter

Many members were present at the Roosevelt Hospital, Metuchen, on March 15, when DR. H. P. FINE called the regular monthly meeting of the *Middlesex County Medical Society* to order.

Two associate members, DR. RAYMOND J. GADEK and DR. FRANK PARET were advanced to regular membership. DR. SEYMOUR LIPSCHUTZ was accepted as an Associate member by transfer from Washington, D. C. A letter was read from Dr. Irvin Sadoff requesting that he be placed on inactive status because he is in the employ of the Veterans Administration. It was decided that he be informed that his only alternatives were to continue his membership or to resign. Instead of accepting the resignation of DR. GEORGE F. LEONARD, who is now retired, it was moved to place him on the honorary membership list because of his long association with the Society.

A letter was read from Dr. John Van Mater to the editor of the Perth Amboy News replying to a published letter protesting the inability of a local citizen to obtain a doctor on Wednesdays, Sundays, or holidays. The editor was informed of the work of the County Society in providing an emergency list of doctors to all physician's exchanges, police stations and hospitals.

A letter from the Panama Canal Railroad Co. cited the shortage of physicians in the Canal Zone caused by withdrawal of the Army. Any doctor interested in filling this need should contact the secretary of the society, Dr. Leo Perillo.

A letter was read from Miss Babette Streitwolf of The Francis E. Parker Memorial Home explaining the limited bed capacity and the means of gaining admission.

A letter from Dr. James F. Norton asked that local physicians endorse The New Jersey Voluntary Cooperative Health Program and give it favorable publicity, since it has been approved by the state society, Blue Cross and Blue Shield. Mr. James E. Bryan, executive officer of the state society discussed the slight shift in public sentiment against the Truman health program, the value of the 1-10-20 plan, and further steps for elimination of the threat of compulsory health insurance, namely encouraging more local group statements to senators and congressmen, providing physician speakers to lay groups, and arranging county press conferences. He discussed the 12 point New Jersey plan which has been evolved as a practical approach to improving health services. This is more specific than the A.M.A. 12 point program, limiting the functions of the federal government to extending income tax reduction on premiums, supporting part or all of the premiums for federal employees, and providing subsidies as needed to certain medical schools or medical students. If this program is unanimously approved by all the county societies, it will be presented to the A.M.A. in June. It was decided to refer this matter to the Board of Trustees, who would report their recommendations at the April meeting.

Dr. Fine then introduced DR. SOLOMON ESTREN of the department of Hematology of Mt. Sinai Hospital and the department of Medicine of the New York University of Medicine, who spoke on "The Spleen and Hypersplenism". He discussed the functions of the normal spleen from evidence acquired by the results of splenectomy, studies of splenic extracts, and studies in parabiosis.

The discussion was opened by Dr. Sylvan Moolten, who described his work with various splenic extracts. Dr. Joseph Sandella pointed to polycythemia vera as an outstanding example of splenomegaly without hypersplenism.

MONMOUTH COUNTY

Lester A. Barnett, M.D., Reporter

Under the chairmanship of DR. HARRY BRINDLE, its president, the *Monmouth County Medical Society* held its regular monthly meeting on March 22, 1950, at the Monmouth Memorial Hospital, Long Branch. The "Present Status of Cancer Research and Its Possibilities for the Near Future" was the subject presented by DR. JOSEPH H. BURCHENAL of the Sloane Kettering Institute, Memorial Hospital, New York City.

On recommendation of the membership committee, DR. FRANCIS A. PFLUM of Asbury Park was elected to full membership, having formerly been a member of the Westchester County (N. Y.) Medical Society.

Dr. John Clark spoke on stimulating the 1-10-20 Plan to better productivity and distributed copies of "The Road Ahead". Dr. George McDonnell, Program chairman, announced the annual dinner-meeting with the Monmouth County Dental Society to be held at Deauxville Inn on April 19.

MORRIS COUNTY

Theodore R. Failmezger, M.D., Reporter

The February meeting of the *Morris County Medical Society* was held on February 16, at The Maltine Company in Morris Plains.

Dr. Earp, chairman of the Post-Graduate Education Committee announced that meetings were to start March 23 and continue through May 11, and are to be held at the Chilcott Laboratories of the Maltine Company at Morris Plains. The program is to include a talk on "Office Gynecology" by Mortimer N. Hyams, M.D., F.A.C.S., "Anesthesia-Obstetrical Analgesia" by Emery A. Rovenstine, M.D., "Infant Care: Modern Trends in Infant Feeding; Care of Prematures; Immunizations", by Charles A. Weymuller, M.D., "Interpretation of Laboratory Tests", by Maurice Bruger, M.D., "Orthopedics in General Practice", by Mario E. Stella, M.D., F.A.C.S., and "Psychiatric Problems in General Practice", by Herbert X. Spiegel, M.D.

It was also announced that the Morris County Chapter of the New Jersey Heart Association had been formed and that all those interested in taking an active part in the work of the organization should contact Dr. George B. Emory, Jr., chairman of the Membership Committee. Dr. George J. Young, president of the Chapter, has urged that as

many members as possible participate in the program.

The speaker of the evening was DR. HAROLD THOMAS HYMAN of Columbia University Medical School. Dr. Hyman discussed "Anti-therapeutic Therapy", in an interesting and enlightening manner.

The March meeting of the *Morris County Medical Society* was held at The Maltine Company on March 16.

Dr. Bertha brought up the question of the formation of a State "Gripe" Committee and it was then urged that the members of the Society familiarize themselves with the purposes and operations of such a committee and be prepared to discuss it at the next regular meeting.

The meeting was then turned over to DR. HARRY ROSE, assistant professor of Medicine, College of Physicians and Surgeons, Columbia University, who spoke on "The Present Status of Antibiotic Therapy". He discussed in detail the use of our presently available antibiotics and also what was in store for us in the future.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on April 18, at the Woman's Club, Paterson. IRVING OKIN, M.D., president, presided.

EDWARD FEENEY, M.D., Pequannock, was elected to active membership and FRANK R. SCHELL, M.D., Paterson, was elected to Associate membership in the Society.

Dr. Okin announced the appointment of the Nominating Committee for the annual meeting of the Society, with William M. Sullivan, M.D., serving as chairman.

The amended Certificate of Incorporation was given its second reading as announced in the meeting notice sent to the members April 12.

On motion by Dr. Joseph E. Mott the Resolution was adopted.

Dr. Okin announced the first reading of the proposed By-Laws as required by our present Constitution and By-Laws. A motion was made by Dr. Harry Wolfson that the reading aloud of the proposed By-Laws be waived; that the proposed By-Laws be mimeographed and forwarded to each member of the Society. The motion was seconded and unanimously carried.

Dr. Okin reported that the Paterson Evening *News* is now in the course of preparing its 60th Anniversary Mid-Century Edition and that it is the recommendation of the Welfare Council that the Medical Society take some space in the edition but that this can only be done with the approval of the members present and voting at a regular meeting of the Society.

It was voted that one-quarter page be taken in the Paterson Evening *News* 60th Anniversary Mid-Century Edition.

Dr. Okin then introduced the speaker of the Scientific Session, SOLOMON S. LICHTMAN, M.D., F.A.C.P., assistant professor of Clinical Medicine, Cornell University Medical College; assistant attending physician, New York Hospital; adjunct physician, Mt. Sinai Hospital, New York. His address, illustrated with lantern slides, covered the symptomatology, and the scientific analysis of hepatic insufficiency.

SALEM COUNTY

John S. Madara, M.D., Reporter

At the regular meeting of the *Salem County Medical Society* presided over by its president, DR. J. ROBERT COX, and held at the du Pont - Penns Grove Club on February 17, 1950, at 4:30 p. m., DR. FRANCIS C. GRANT of the University of Pennsylvania Graduate School of Medicine, spoke on *Low Back Pain*. He stressed the early diagnosis and subsequent treatment of the ruptured intervertebral disc— "a disease of the worker".

It was announced by Dr. Harry F. Suter that plans had been completed for the essay contest on "Socialized Medicine" to be held in the high schools of Salem County. Dr. Suter also gave an interesting summary of a meeting of the Welfare Committee he had attended on January 18, in Trenton.

After a lively discussion on the advisability of physicians allowing their names to be used in local radio program advertising, the meeting adjourned to dinner.

An interesting meeting of the *Salem County Medical Society* was held at the du Pont - Penns Grove Club on March 17, 1950, under the chairmanship of its president, DR. J. ROBERT COX.

The speaker-of-the-day was DR. LEANDRO M. TOCANTINS of the Department of Hematology of Jefferson Hospital in Philadelphia. He spoke on *Common Blood Dyscrasias*, and particularly emphasized the systemic hemostatic agents (Vitamins K and C, protamine, toluidin-blue, antihemophilic globulin and epinephrine) and the local hemostatic agents (thrombin, epinephrine and gelfoam or oxycel).

A committee consisting of Drs. Green, Fullerton and Evans was formed to study Temporary Disability Insurance; and another to arrange for a meeting with the press (Drs. Madara and Fullerton).

SOMERSET COUNTY

Irving Klompus, M.D., Secretary

The regular meeting of the *Somerset County Medical Society* was held on February 9, 1950, at the Somerset Hospital Nurses' Home. The meeting was called to order by the president, DR. MASON PITMAN.

Dr. Cook introduced the speaker of the evening, LEES M. SCHADEL, M.D., associate professor of Obstetrics and Gynecology, Hahnemann Medical School, who gave an illustrated lecture on "A New Method of Obstetrical Anesthesia and Analgesia".

WOMAN'S AUXILIARY

MRS. R. JOHN COTTONE, PRESIDENT, 1950-1951

Mrs. R. John Cottone, a native of Nebraska, is a graduate of Fremont Normal School and Boyle's Secretarial School in Omaha. She is a member of St. Francis Hospital Aid, The Contemporary Club and The League of Women Voters, of Trenton.

Mrs. Cottone has been active in the Auxiliary to the Mercer County Medical Society since 1940 and served as president in 1946-47. She has served the State Auxiliary for ten years, as a member of the Chairman's Committee, in various projects. During 1949 she was conference Chairman and president-elect.

Dr. and Mrs. Cottone were married in 1926 and have two sons, John and Robert, both students in Georgetown University. John will enter Georgetown Medical School in September 1950 and Robert will be a member of the sophomore class in the College of Arts and Sciences. Dr. Cottone is a surgeon on the staff of St. Francis Hospital, Trenton.

ACCEPTANCE OF THE GAVEL

Mrs. R. John Cottone, President

The time of the passing of the gavel is a significant one in the life of our Auxiliary. Not merely because of our regret at the passing of a well tried and well loved leadership, but because at this point we pause to evaluate ourselves.

As a national organization we now number over 50,000 women and as a state we have passed the 1500 mark. As we grow we also assume greater responsibilities. Our national President, Mrs. Allman gave us this inspiring message in our *Bulletin* "I feel that today we are a part of the American Medical Association rather than simply an auxiliary to it". This place we have gained by the work we have accomplished in making the voice of the people heard in the halls of Congress on the subject of national health.

Our place in the progression of plans and ideas for the coming year must be an important one. The American system of health care has aided in making this country strong, may still be under attack and so we must still meet this challenge and carry forward, with strength and energy, the great educational program so well begun. We must step up the tempo of our program, to secure more endorsements, accelerate enrollment in voluntary health insurance plans, distribute more literature, study well all new health legislation and assist in the improvement of rural health and school health care throughout our state. We must bend every effort toward increased membership—we should have the wife of every medical society member in our Auxiliary. Each member adds

strength to our force and with our varied endeavors, we can find work to interest all.

In all that we do we will not be unmindful of our need for the advice and support of our medical society and that our purpose is to assist only where needed and to correlate and coordinate, in orderly and harmonious attitude, our work with theirs.

I am most grateful to this membership for the honor of serving as your President this year. I fully realize the responsibilities falling upon one who is to follow such officers as have served so well. However, I feel a strong confidence in the loyalty of our members and their willingness to cooperate.

Therefore I pledge my loyalty to The Woman's Auxiliary to The Medical Society of New Jersey and promise that I will do all in my power to help you make the coming year a prosperous one for the organization.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

The members of the *Woman's Auxiliary to the Medical Society of Atlantic County* were entertained at their meeting which was held on April 14, at the Hotel Traymore, by the son of one of their members.

Jack Reyner, son of Dr. and Mrs. Daniel C. Reyner and a former pupil of Dr. Joseph Lilly, played several selections on the piano. Although an amateur, Jack played with skillful technic and unusual sensitivity. His selections, "Staccato in D Minor" by Bach, "Fantaisie Impromptu" by Chopin, and "Malaguena" by Lecuon, were enthusiastically received. As an encore, Jack played excerpts from Grieg's "Concerto in A Minor".

Mrs. Louis Rosenberg, president, presided over the business meeting at which time Mrs. Robert A. Bradley, chairman of Arrangements, announced that the next meeting would be in the form of a luncheon, honoring the outgoing president, and would be held on May 12, at the Hotel Traymore. Mrs. Harry Subin is in charge of the affair and her co-chairman is Mrs. Alan Rieck. The officers for 1950-51 will be elected and installed at this luncheon.

Mrs. Subin, chairman of the nominating committee, read the following slate: President. Mrs. Clarence Whims; President-Elect, Mrs. Matthew Molitch; First Vice-President, Mrs. Rolfe Westney; Second Vice-President, Mrs. E. Harrison Nickman; Treasurer, Mrs. Arthur Dintenfass; Recording Secretary, Miss Gertrude Guion; Corresponding Secretary, Mrs. Sterling Brown.

Mrs. G. Ruffin Stamps, chairman of Public Relations announced that the State Public Health Conference which will be held soon in Trenton will concern itself with mental health and handicapped children.

Bergen County

Mrs. Carl Rothschild,
Chairman, Press and Publicity

Thirty-eight members of the *Woman's Auxiliary to the Bergen County Medical Society* met on April 11, at the Chimes Restaurant in Paramus, for lunch and their annual Spring meeting, at which time officers for the year 1950-51 were installed.

Mrs. Walter Jordan, retiring president, opened the meeting on a sad note by asking all present to pay silent tribute to the memory of one of their active members and close friends, Mrs. Charles Littwin, who had just passed away.

Annual reports were read by the various retiring officers and committee chairmen. A partial list of the group's activities for the year include a Christmas Dinner-Dance at the Chimes Restaurant, a Dessert Bridge and Fashion Show at the Hackensack Women's Club and a Valentine Tea at the Englewood Hospital. The first two affairs were fund raising projects, and the profits have been earmarked for charitable purposes. Mention also was made of the Auxiliary's work in establishing an Rh Negative Donor's Club here in Bergen County.

Mrs. Jordan then turned to the important business of the day—installation of the incoming officers. They are: President, Mrs. Edward Sexton; President-Elect, Mrs. Rufus Little; First Vice-President, Mrs. Thomas Garrett; Second Vice-President, Mrs. Matthew Feldman; Treasurer, Mrs. Walter Modrys; Recording Secretary, Mrs. Sam Joseph; Corresponding Secretary, Mrs. Luke Mulligan.

Chairmen of the standing committees, appointed by Mrs. Sexton are Public Relations, Mrs. Thomas Garrett; Membership, Mrs. Matthew Feldman; Program, Mrs. Stewart Alexander; Hospitality, Mrs. G. A. Hoffman; Publicity, Mrs. Carl Rothschild; Rh Negative Donors Club, Mrs. Rufus Little; Historian, Mrs. Samuel Alexander; Legislation, Mrs. Vincent McAuliff; Budget, Mrs. William Magee.

Camden County

Mrs. Thomas M. Kain, Jr.,
Chairman, Press and Publicity

"Emotional Problems of Living" was the theme of the Institute held March 21, by the *Woman's Auxiliary to the Camden County Medical Society*, for its annual Public Relations Meeting. The event took place at the Haddon Fortnightly, Haddonfield from 10 a. m. to 3 p. m. Between the morning and afternoon meetings, light luncheon was served by members of the Auxiliary.

Dr. Constantine Roscoe, pediatrician, Jefferson Medical College and Hospital, explained "Rooming-in of the Newborn", at 10 a. m. Dr. Louis H. Twyeffort, psychiatrist, University of Pennsylvania

School of Medicine, spoke on "Problems of the Adolescent" from 11 a. m. until noon. The afternoon session opened at 1 p. m. with a talk on "What Do Children Need from Parents" by Mrs. Maria E. Shelmire, executive director, Family Service in Delaware County, Pa. From 2 p. m. to 3 p. m., "Psychiatric Aspects of Alcoholism" was discussed by Dr. H. Edward Yaskin, chief neurologist, St. Luke's Hospital and Children's Medical Center and director of the C. Dudley Saul Clinic.

Mrs. William Braun, Public Relations chairman, arranged the program assisted by Mrs. Arthur L. Stone, co-chairman.

Dr. A. M. K. Maldeis, president of the Camden County Medical Society, welcomed the large group attending. Mrs. Harold K. Eynon, president of the Auxiliary, introduced Mrs. William Braun, who presided.

Hudson County

Mrs. Arthur P. Trewhella,
Chairman, Press and Publicity

The annual Open Health Meeting of the *Auxiliary to the Hudson County Medical Society* was held on March 6, at Murdoch Hall, Jersey City. Mrs. Fred Sachs, chairman of Public Relations, presented Dr. Vincent Butler, president of the County Medical Society, as moderator of the forum on Heart Disease, Its Prevention and Treatment. The following Hudson County physicians spoke on various aspects of the subject: Dr. Carroll Leevy, on the Various Types of Heart Diseases; Dr. Emil Grieco on Prevention of Heart Diseases; Dr. L. J. Garibaldi on Treatment of Heart Diseases; Dr. Thomas White on What Can be Done About Heart Diseases. Over 200 lay organizations were represented. A discussion period followed the talks. A variety of questions from the audience testified to the wide interest in the subject. A social hour with refreshments concluded the program.

The annual meeting of the Auxiliary was held on April 6, at Murdoch Hall, Jersey City. Mrs. Sydney Chayes, president, called for the annual reports of the officers and chairmen. The resignation of Mrs. Francesco Figurelli was accepted with regrets. The following officers will be inducted at the May meeting: President, Mrs. John Muccia; First Vice-President, Mrs. Morris Bresev; Second Vice-President, Mrs. Marshall Bergen; Recording Secretary, Mrs. Euclid Ghee; Treasurer, Mrs. Harry Perlberg; a President-Elect will be elected to fill the present vacancy in that office.

Delegates to the annual convention in Atlantic City in May are: Mrs. Sydney Chayes, Mrs. Vincent Campana, Mrs. Abraham Jaffin, Mrs. Edward Murphy, Mrs. Arthur Trewhella. Alternates will be: Mrs. William Mulvihill, Mrs. Louis Norwich, Mrs. Andrew Pecoraro, Mrs. James Tsucalas.

It was announced that a Tea and Reception will be given at the Jersey City Woman's Club on Sunday, April 30, in honor of the doctors of the Hudson County Medical Society. Plans are also under way for the annual Play Day to be held on May 15 at the Cresmont Country Club.

Somerset County

Mrs. Harold N. Wender, Press and Publicity

Mrs. John Patten of Somerville was elected president of the *Woman's Auxiliary to the Somerset County Medical Society* at a luncheon meeting on March 20. She succeeds Mrs. Scott McKinley. The other officers elected were: Mrs. J. Young, President-Elect; Mrs. J. L. Spaldo, Vice-President; Mrs. A. Stolow, Treasurer; Mrs. M. Tolomeo, re-elected Secretary.

Over thirty schools have already answered asking for their free copies of *Hygeia* magazine. Letters were sent to all elementary and high schools in Somerset County by the Auxiliary, telling them that the health magazine will be sent them free of charge at their request.

Many of the health programs offered by the group have been shown to schools and other public groups complete with films and addresses by local physicians, the latest showing having taken place in Warren Township with the movie "Cost of Serious Illness" and an address by Dr. Lewis Fritts of Somerville.

BOOK REVIEWS

A Century of Medicine in Jacksonville and Duval County. By Webster Merritt, M.D. Pp. 220. Illustrations 44. Gainesville, Fla.: University of Florida Press, 1949. ($3.50)

Physicians and laity alike will find in this engaging narrative an interesting contribution to Florida's medical and historical lore. With the forthright touch of the true historian, Dr. Merritt presents in panoramic review the fascinating events, towering personalities and progressive movements of the entire nineteenth century as they pertain to medicine in Jacksonville and Duval County. His exhaustive research has brought to light in highly readable form history long obscured, owing to loss of records in the Jacksonville fire of 1901. In sifting out the facts for this entertaining and accurate account, he pictures the physician as community builder and harbinger of progress as well as practitioner of medicine, and his facile pen loses none of the drama of the terrifying yellow fever and other epidemics or the gala events of the times. With equal skill he traces the foundation and early history of the Florida Medical Association. The book is profusely illustrated throughout its twenty chapters and makes a colorful addition to any library.

Ulysses M. Frank, M.D.

Haemolytic Disease of the Newborn. By M. M. Pickles, M.D. Pp. 181. Springfield, Illinois, Charles C. Thomas, Publisher, 1949. ($4.50)

Infant mortality rates are unsatisfactorily high in the United States as well as in all other countries. Most infant deaths occur in the first forty-eight hours of life and are usually the result of disorders that are so severe that even the improved therapy of modern pediatrics is of no avail. Therefore, any significant reduction in neonatal mortality must come from increased efforts by the obstetrician to produce more viable, treatable newborn infants. One important means towards this end is now available to the obstetrician in the rapidly accumulating knowledge concerning blood incompatibilities of mother and child, iso-sensitization and erythroblastosis fetalis. Dr. Pickles treats the subject as a disease entity and her presentation is detailed enough to make this monograph "invaluable to the serologist and hematologist". Her discussion of the mechanism of immunization, the pattern of the disease and the management of the pregnancy is of great help to the obstetrician while her practical points on treatment of the affected infant facilitate the pediatrician's work.

Dr. Pickles' material is based on a study of 73 families with 116 affected children. The study occupied five of the nine years since our own Doctors Levine and Katzin first reported their theory, and its proof, that erythroblastosis fetalis (with its attendant disease states and sequelae) is due to Rh incompatibilities. The author emphasizes the value of routine antenatal testing of women for the Rh factor, properly evaluates the significance of a negative finding, and advises the course of action to be taken during pregnancies with a past history of hemolytic disease. In her discussion of indications for induction of premature labor and for exsanguination transfusion of the infant, she has ably avoided the controversial aspects of these problems. This book provides a great deal of useful information on a very important subject in such a manner that desired facts are easily found.

ARTHUR HEYMAN, M.D.

Helpful Hints to the Diabetic. By William S. Collens, M.D., and Louis C. Boas, M.D. Pp. 135. Springfield, Ill., Charles C. Thomas, 1949. ($3.00)

To write a manual of instruction which would be suitable for all diabetic patients is almost impossible. One's own beliefs and shades of feelings on the treatment and handling of the diabetic must influence one's instruction. What Collens and Boas may write in their book may appear as anathema to patients of Joslin or Tolstoi. With these difficulties and implied limitations in mind the reviewer feels that the authors have struck a fairly happy middle course in this handbook primarily addressed to the laity.

Diets are simply explained without setting too rigid a pattern; but no complete menus are included for examples, always a good method of diet instruction. Insulin administration and timing with relation to meals is well-covered and diagrammed. The series of prints on the injection technic are excellent but the method of making insulin mixtures is more subject to error than an alternate method in fairly wide use.

Only very fleeting reference is given to the great influence of exercise on insulin action and diet. The latter should be given more space in a lay handbook.

Arteriosclerosis and other diabetic complications are clearly discussed. Insulin shock, discussed in such a manner as to reassure the lay reader, is passed over somewhat lightly. There is some question in the reviewer's mind as to the advisability of including quantitative urine glucose determinations in such a book, but the authors explain that this is a test which "the more meticulous diabetic" may want to use.

Both the question and answer section and list of definitions are very instructive. In spite of the book's limitations, this is probably one of the simplest, most understandable, and least controversial diabetic manuals published to date and could well be recommended by physicians to their patients.

EVERETT O. BAUMAN, M.D.

The Development of Gynaecological Surgery and Instruments. By James V. Ricci, M.D. Pp. 594. Philadelphia, The Blakiston Company, 1949. ($12.00)

This book follows the pattern of Ricci's previous historical publications. A thorough and deep understanding of the essentials of medical history are apparent throughout the work. He writes that "the present generation of gynaecologists (his spelling of gynaecology is etymologically the only correct one) has seemingly turned its back to the past". And he is certainly right. Looking into the past of previous generations of operating physicians throughout the centuries, will make us humble and prevent us from overrating the present status of gynecologic surgery. The author's descriptions of gynecologic operations and instruments, based on excellent references to the literature, can even teach our contemporaries or, at least, give them a better understanding for their work. Gynecologic surgery of the old Greeks and Romans, and the tools they used for it, were at a very high level and this work of Ricci's documents the evidence.

It is interesting to note the great interest these older colleagues displayed in the surgical treatment of the vesico-vaginal fistulae indicating that obstetrics in their time furnished them with much illustrative material. The integration of proper application of sutures, anesthesia and asepsis into gynecologic surgery produced, of course, better results; but the technic used even before these inventions cannot but arouse deep admiration for the work of those preceding us.

Ricci's book is not only valuable to the historian, but also to the gynecologist who wishes to know more about his field over and beyond that acquired through experience or teaching.

BEN LIEBNER, M.D.

Book Reviews continue on next page.

Life Among the Doctors. By Paul De Kruif in collaboration with Rhea De Kruif. Pp. 470. New York, Harcourt, Brace and Co., 1949. ($4.75)

This book presents an interesting series of biographies of "mavericks" who did pioneer work in American medicine. While the layman will swallow De Kruif's enthusiastic reporting, the scientist will question some of his sweeping generalities.

One is impressed by the struggles and lack of appreciation for the merit of the scientific problems tackled by De Kruif's heroes. Tom Spies almost lost his nutrition clinic because he championed multiple vitamins. He succeeded in carrying out his work with the help of foundations, commercial laboratories and universities. Cy Young's splendid contributions to public health laboratory work were a real service to the doctors in Michigan, especially when physicians know that Cy Young was willing to look for the green producing streptococcus of subacute bacterial endocarditis in every patient with a fever and heart murmur. His laboratory rendered service to all doctors of Michigan and supplied free toxoid and vaccines.

The chapter on rheumatic problem is excellent and the hero is Al Coburn. Leo Loewe saved many lives by treating subacute bacterial endocarditis with heparin, massive doses of penicillin and caronamide. Karl Meyer receives praise for work on equine encephalomyelitis, botulism and plague. De Kruif did not stress a sensational epoch in Karl Meyer's studies on mussel poisoning or dinoflagellate poisoning.

Wenger's unorthodox but efficient methods of combatting venereal disease furnish a merry chapter in the book. Wenger, unappreciated by the "brass" in Washington, turns to arthritis work and as usual distinguishes himself.

Herman Kabat's work with prostigmin and physio-therapy for relief of muscle spasm in multiple sclerosis and various neurologic conditions such as polio is outstanding.

In the chapter on the early treatment of cancer De Kruif aims to show that many cases classified as incurable by surgeons have responded to x-ray and radium. Time alone can answer this argument.

The discriminating doctor will find much to praise and much to criticize in this book. It is hoped that the layman lacking the medical judgment of the physician will not jump to false conclusions and unreasonable optimism.

Henry Simon, M.D.

Physiology of Heat Regulation and the Science of Clothing. Edited by L. H. Newburgh, M.D. Pp. 457. Philadelphia, W. B. Saunders Company, 1949. ($7.50)

What are the climatic limits in which man can live? To what extremes of heat and cold can the human endure and adjust? These queries set off a series of experimental investigations fully reported in this timely book. Edited by the Professor of Clinical Investigation at the University of Michigan Medical School, it is a complete and detailed description of the physiologic and physical responses of humans to the whole range of climatic conditions on the earth's surface.

These experiments began during the recent war by civilian researchers appointed by the National Research Council. The military command was in great need of information on heat regulation. "In earlier wars," the editor explains, "generals planned their campaigns to begin when the weather would not be a serious detriment. In World War II, however, the fighting took place at any time, regardless of intense cold and deep snow, sodden half-frozen earth, burning desert sunshine, or humid tropical heat. For the first time, aviators in significant numbers were exposed to very low temperatures of the upper air and to sudden immersion in fatally cold water when they were shot down."

This book is a compendium of the latest and most valuable findings in the field of body heat regulation. Dr. H. C. Bazett, Professor of Physiology at the University of Pennsylvania, has contributed a chapter on the regulation of body temperatures. Dr. L. P. Herrington, Director of Research at the Pierce Laboratory in New Haven has written on the range of physiologic responses to climatic heat and cold. One section of the book deals with clothing as a protection against climatic extremes. Dr. Paul A. Siple, of the U. S. Army General Staff, has described what factors influence the selection of clothing for a given environment and what our fighting men were wearing during World War II in the way of protective body covering. It is amazing to read of the scrupulously thorough testing that went into the design and texture of army uniforms to make certain that they were scientifically constructed.

Any scientist interested in the latest developments in this field will find the "Physiology of Heat Regulation," a valuable and absorbing reference book.

Philip A. Berke, Ph.D.

Antibiotics. Edited by George W. Irving, Jr., Ph.D., and Horace T. Herrick. Pp. 273. Brooklyn, N. Y., Chemical Publishing Co., Inc., 1949. ($6.75)

This is a collection of lectures published under the auspices of the United States Department of Agriculture. The lecturers include distinguished men of science such as Selman Waksman, Chester S. Keefer and Rene J. Dubos. Painstaking revision of the lecture texts prevented overlapping with most of the material dealing with production, analysis, certification and refinement of the materials. As a result, the direct practical value to the physician is not great.

The printing is on excellent glossy paper, the subject is covered in a readable and basic form useful to students and workers in antibiotics.

Irving Shapiro, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **June, 1950** **No. 6**

AFTER many years of observation and careful experimentation BCG vaccine is now being recommended in this country for use with certain population groups as a protection against tuberculosis. The Public Health Service is now ready to issue licenses for the production and distribution of BCG vaccine to physicians.

BCG VACCINATION

Calmette and Guerin

The initials BCG stand for Bacillus of Calmette and Guerin. It was named for the two French scientists who, using a potent bovine strain of tubercle bacillus isolated in 1902, were able to show a sharp reduction in virulence of the organism after repeated passage on an artificial medium. This finding led them to consider the possibility of further reducing the virulence of the strain in order to develop a living vaccine which by causing a mild and harmless infection would protect human beings against the invasion of more virulent organisms.

In 1908, Calmette and Guerin announced that they had developed a strain of bovine tubercle bacilli which had no virulence for cattle. Twelve years later, they reported that this BCG culture was harmless to man. Later studies of groups vaccinated with BCG confirmed this and showed a lowered illness rate and death rate for tuberculosis over varying periods of time in these groups.

This certainty, however, was not immediately reached. Lack of proper controls during the early work done with this vaccine, together with the difficulty of maintaining the fixed nonvirulent strain of the tubercle bacillus, retarded its widespread use. Over the years, the resistance to the use of BCG has been partially conquered, and it is now widely accepted as an effective tool when used in conjunction with other techniques of tuberculosis control.

Misunderstandings

Certain misconceptions about the use of BCG vaccine still persist. First of all, the vaccine is given only to those persons who are negative reactors to the tuberculin test. Over many centuries, the human race has become fairly resistant to tuberculosis. The majority of persons sooner or later become infected with tubercle bacilli and are positive reactors to the tuberculin test. They do not, however, in the vast majority of instances, develop real tuberculous disease. Although a certain immunity is gained through infection with the disease germ, a chance infection with virulent germs is not a satisfactory method of immunization. An infection with a mild harmless strain of tubercle bacilli can be overcome by protective antibodies which may, in time, combat a future invasion of virulent germs. BCG vaccine is designed to strengthen resistance and thereby protect against a disease that might otherwise be disabling or fatal.

Groups to Be Vaccinated

Public health authorities consider it wise to confine BCG vaccination to groups such as nurses, medical students, and hospital personnel who are occupationally exposed to tuberculosis and to those who will be in direct contact with a person who has an open case of tuberculosis.

Vaccination is not undertaken when general weakness, minor infections, measles, whooping cough, eczema or furunculosis are encountered. BCG vaccination is not combined with vaccinations against other infectious diseases such as smallpox, diphtheria, typhoid fever or tetanus.

BCG Is No Cure

BCG is a preventive measure, not a cure or a method of treating tuberculosis, and is used always

as an adjunct to other methods of controlling the disease. Finding cases, isolating and treating them, rehabilitating and returning them to normal lives are the principal methods of fighting this disease. BCG can reduce the number of persons who will become tuberculous, but it can in no way assist in fighting the disease after it has been contracted.

Duration of Protection

At the present time it is not possible to say that BCG provides immunity over any definite number of years. Research will, doubtless, provide us with reassuring answers in the future.

How Vaccination Is Done

BCG vaccination should be done only by those physicians who have observed the technique. Four methods of administering BCG vaccine are in use.

Birkhaug's Method

Birkhaug's method employs a spring-actuated 38 needle instrument that performs a multiple puncture vaccination with one downward action. A 4 x 4 centimeter piece of sterilized thin paper or cellophane is moistened on both sides with BCG vaccine and place on the ether-cleansed skin. The skin is held taut. The head plate is evenly pressed against the paper, and the tripper is pushed. The needle points become coated with the vaccine as they perforate the paper and enter the skin.

Rosenthal's Method

With Rosenthal's method, the physician draws the required quantity of vaccine into a syringe with a 19-gauge needle. The skin is kept taut and three or four drops of vaccine are placed over the ether-cleansed area of the arm or thigh and spread evenly with the side of the needle over a small area. Twenty to forty pressure punctures in four or five rows about a half centimeter apart are then made, and the vaccine is rubbed gently over the punctured area with the side of the needle.

Scarification

When the scarification method is used, the ether-cleansed area of the skin is not punctured, but three or four short linear scarifications are made across the drops of the vaccine either with syringe needle or a sewing needle. While the skin is held taut, the vaccine is rubbed gently over the area with the side of the needle. This method is not recommended by the New York State Department of Health.

Injection

The intracutaneous method requires vaccine which contains 1.0 milligram of microorganisms per milliliter instead of 20 milligrams as used in other methods of vaccination. The outer surface of the left upper arm or thigh is cleansed with ether or alcohol, the skin is held taut and 0.1 c.c. of the vaccine is injected between the layers of the skin using a tuberculin syringe with a fine needle.

BCG Only One Tool in Tuberculosis Control

When carefully carried on by experienced physicians, BCG vaccination causes no untoward reaction and promises to protect individuals against tuberculosis. When used as a part of the general tuberculosis control program, BCG provides us with one more means of attack on an age-old disease enemy of mankind. In the war-devastated countries of Europe, the World Health Organization is pushing forward to a mass vaccination, the results of which may prolong the productive lives of many persons who, without such protection, would fall victim to tuberculosis.

BCG Vaccination, Howard C. Stewart, M.D., N. Y. State Dept. of Health, Health News, December, 1949.

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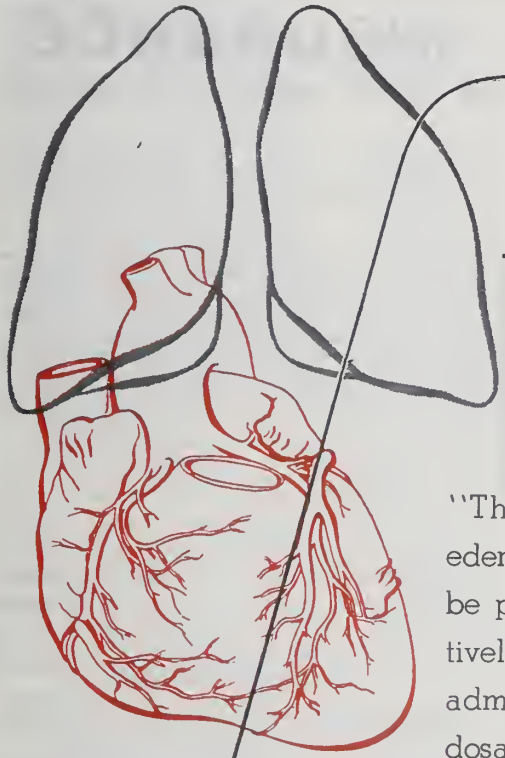

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1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

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GYNECOLOGY—Intensive Course, two weeks, starting June 19, September 25. Vaginal Approach to Pelvic Surgery, one week, starting September 18.

OBSTETRICS—Intensive Course, two weeks, starting September 11.

MEDICINE—Intensive General Course, two weeks, starting October 2. Electrocardiography and Heart Disease, two weeks, starting July 17. Gastroscopy, two weeks, starting July 17, September 25.

DERMATOLOGY—Formal Course, two weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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CONTENTS—Pages 311 to 360

EDITORIALS— Page

President's Message: The Committee System 311

Hospital Publications 312

ORIGINAL ARTICLES—

"Then Conquer We Must—" — Professor Richard I. Nevin, Jersey City, N. J. 313

Carcinoma of the Trachea Simulating Asthma — J. D. Goldstein, M.D., and B. Eisenstein, M.D., Jersey City, N. J. 315

Obstetrical Responsibility in Neonatal Deaths—Alfred Meurlin, M.D., East Orange, N. J. 318

Significance of Rectal Bleeding—Irving G. Larkey, M.D., Newark, N. J. 322

Malignancy of the Thyroid — Edward F. Sciorsci, M.D., Hoboken, N. J. 324

Hypersensitiveness to Insulin — Joseph Skwirsky, M.D., Newark, N. J. 327

Blood Procurement—C. A. Pons, M.D., and S. C. dePons, M.D., Asbury Park, N. J. 331

The Problem of Endometriosis—Edward N. Bookrajian, M.D., and Roy Morrow, M.D., North Bergen, N. J. 332

ORIGINAL ARTICLES— Page

Diagnosis of Carcinoma of the Breast by Cytologic Technic—Benjamin D. Jacobson, M.D., New Brunswick, N. J. 337

STATE ACTIVITIES—

Haddon Hall Highlights 339

Scientific Exhibit Awards 339

Bar Association Opposes Compulsory Health Insurance 340

Obituaries 340

House of Delegates—Abstract 341

Trustees' Meetings 343

State Epilepsy Program 346

Resolution on the Death of Dr. Scott 348

A.M.A. National Advertising Program 348

Supplementary List of Members No. 4 349

New Proctology Journal 349

COUNTY SOCIETY REPORTS 350

WOMAN'S AUXILIARY 354

PUBLIC HEALTH NEWS 356

BOOK REVIEWS 347, 357

TUBERCULOSIS ABSTRACTS 359

Roster of Officers and Committees, Advertising pages 3A 7A

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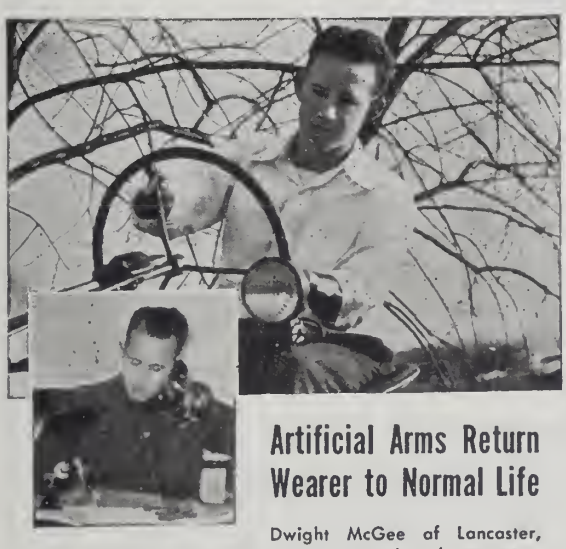

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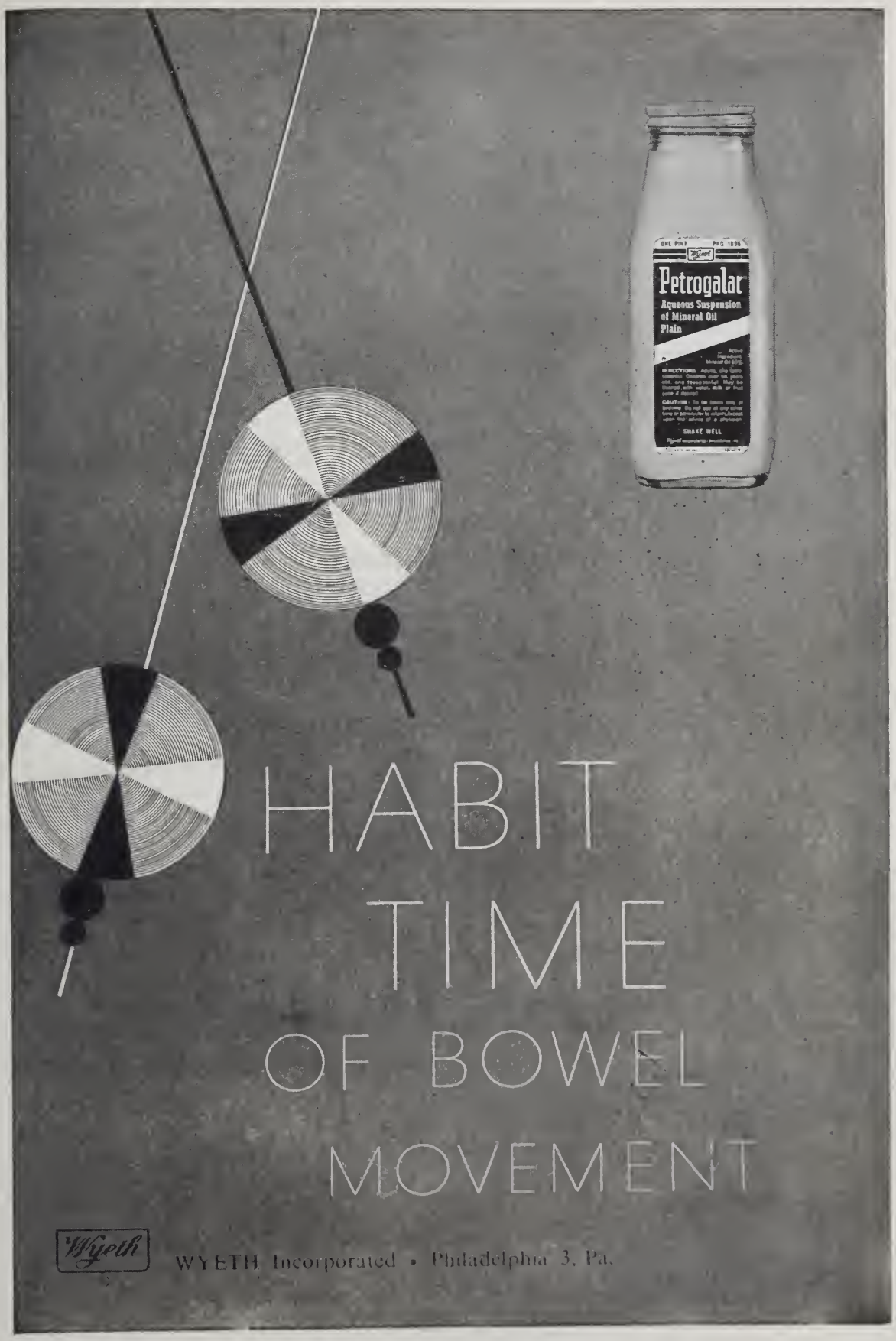
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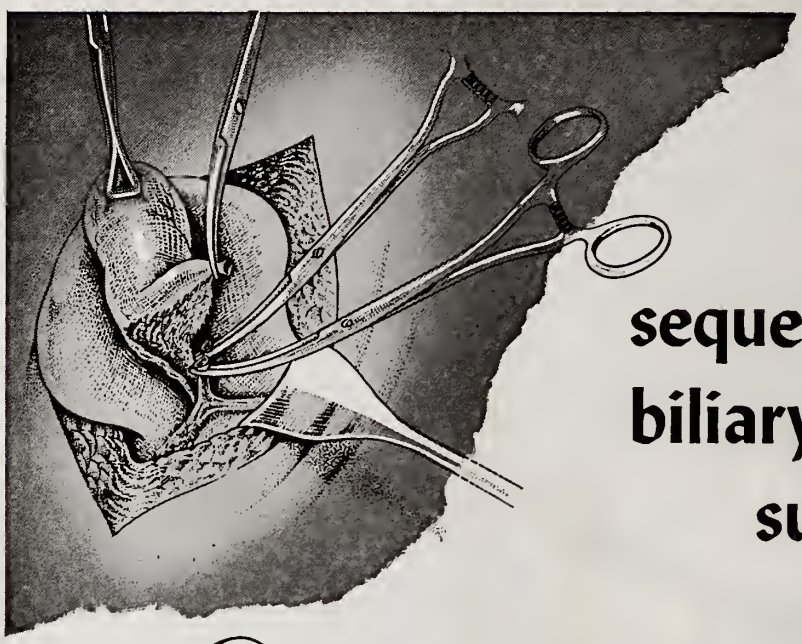

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1. Best, R. R.: Ann. Surg. 128: 348 (Sept.) 1948.

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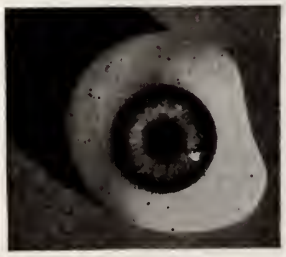

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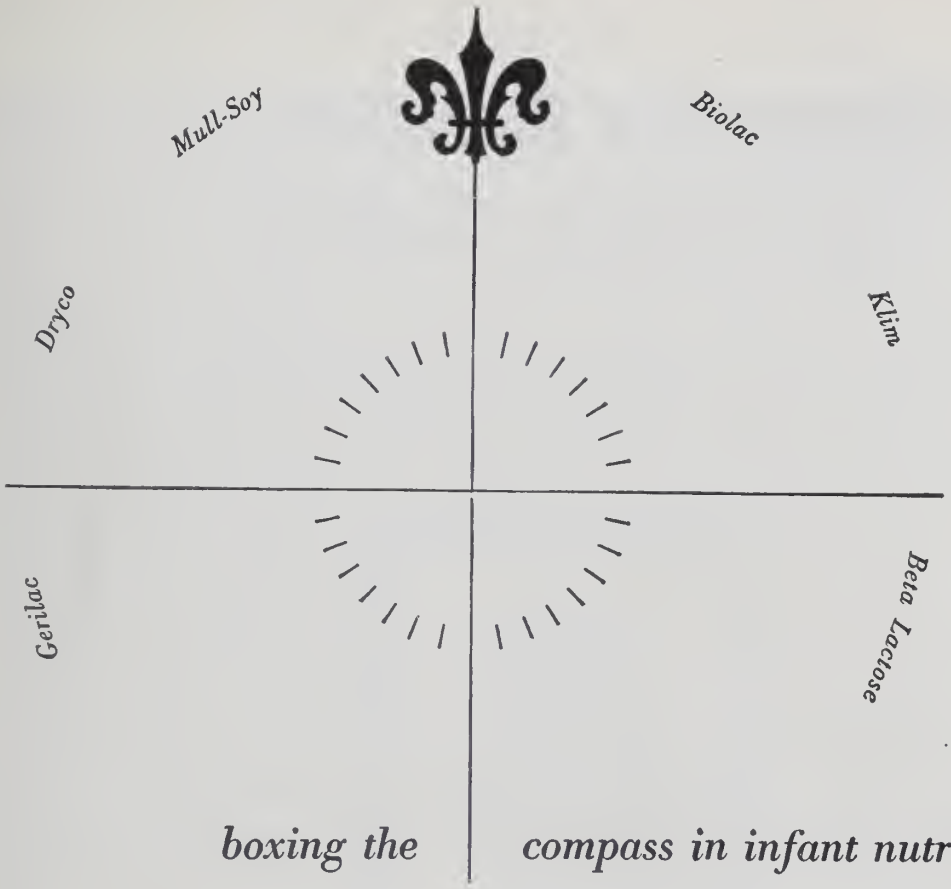

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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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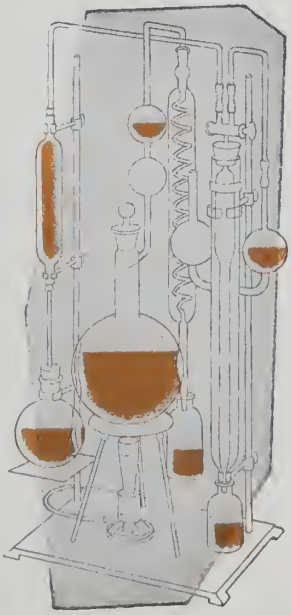

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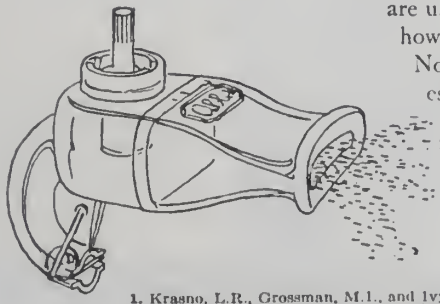

1. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1949). The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust). J. Allergy, 20:111, March. 2. Krasno, L.R., Grossman, M., and Ivy, A.C. (1948). The Inhalation of Norisodrine Sulfate Dust. Science, 108:476, Oct. 29.

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PRESIDENT'S MESSAGE: THE COMMITTEE SYSTEM

Some wit once defined a committee as a body that keeps minutes and wastes hours. Committees, in fact, have been criticized ever since the first cave-man organizer lifted his club and called a meeting to order. But in spite of all the criticism, no one has found a better instrument for democracy in action than the committee. Take our own society, for instance. There is simply no practical way in which 5000 members can sit down around a table and think through the problems of the organization. In the absence of any more direct method, a society can keep moving by only two methods. Either the officers make all the decisions; or the work is broken down into various areas and assigned to committees for study and recommendation. Obviously the latter method is the more democratic. Any member who really wants to work for his organization can sooner or later obtain a committee assignment. And within the confines of the committee room, he has ample opportunity to be heard. In most organizations, in fact, the leaders started on their organizational careers by accepting committee appointments. From the point of view of the member, the committee is the first rung up the ladder of organizational advancement.

It is, however, much more than that. It is the place where issues can be discussed fully and freely. It is the channel between each member's individual ideas, and the ultimate implementation of those ideas by the organization as a whole. Whether a committee wastes time or whether it does a job depends entirely

on the individual members. The first essential is to attend the meetings. I note with pleasure that at the Welfare Committee and its Subcommittee sessions on June 4, the attendance was gratifying. The attendance was 8 out of 10 for Public Relations, 8 out of 9 for Legislation, 12 out of 14 for Medical Practice, and 14 out of 15 (93 per cent!) for Public Health. That's a score to be proud of. The second essential is participation, and there was plenty of that at Trenton on June 4. This wonderful start makes your officers hope that our committees are going to function in high gear. Any member of The Medical Society of New Jersey with a problem to solve, a grievance to air, or a suggestion to make, can easily find the committee having original jurisdiction over the matter. He can communicate with the chairman, with the assurance that his ideas will receive serious consideration. Usually, he can ask to be heard personally at a committee meeting. There will be no chance to say that a member is without opportunity to have his ideas presented.

The committee net-work of your Society grew to its present complexity precisely because it was considered important to have small groups of hard-working members studying a rich variety of problems. These committees are the eyes and ears of the Society. The thanks of your President and of the Trustees go out to every member who has agreed to give of his time and energy to make this committee mechanism work smoothly. It is hoped that every committee member will take his duties seriously and keep the committees rolling with the momentum so well established last month.

Aldrich C. Crowe, M.D.

HOSPITAL PUBLICATIONS

Since New Jersey has no medical school, the job of graduate medical education falls jointly on the shoulders of medical societies and hospitals within the state. It is good, therefore, to note that 1950 marks the debut of two top-notch publications emanating from hospitals in Newark. *Clinical Conferences* is a book prepared by the staff of St. Michael's Hospital and set up under the editorship of Dr. Nicholas A. Antonius. It is a substantial volume covering 150 pages, well printed, and presenting clinical-pathologic conferences covering fourteen instructive cases. The editors have wisely chosen to preserve the informal, fluent, conversational style of the conferences themselves. The book is a veritable graduate course, and as the volumes accumulate they will form a valuable library. It is to be hoped that in future issues it will be possible to present illustrations of the relevant pathologic material and roentgen films.

The second newcomer in the field of hospital journalism is the *Journal of the Newark Beth Israel Hospital.* This quarterly offers scientific monographs of high standard, excellent illustrations, and hard-hitting editorials. It is printed on good glossy stock, and appears under the editorial direction of Dr. Irving L. Applebaum. Both this *Journal* and the book of *Clinical Conferences* represent enterprises in which the two Newark hospitals may take pride. They signal the fact that the staffs of these two institutions propose to remain abreast of the tide of medical advance. They are a credit to the hospitals, and the staffs are to be congratulated on the publications. One adds a hope that other institutions will follow this lead.

ORIGINAL ARTICLES

"THEN CONQUER WE MUST ——"

THE ELIAS J. MARSH ORATION *

Professor Richard I. Nevin, Jersey City, N. J.

In the nature of the assignment which is mine, I cannot but be conscious of the honor that you do me; and if there seems, in what I am about to say, some element of the incongruous in the light of what has gone before, attribute it, if you will, to the determination of the membership of your society at this time, annually, to commemorate these great men.

The purpose of the Elias J. Marsh Oration, as I understand it, is not only to keep alive among you the memory of these distinguished practitioners of medicine, but at this time, once a year, to memorialize formally in this gathering, the contributions made by great men, both to the progress of medicine and to the advance of life, in America.

To do honor to these men, we must realize that your best service and the best expression of our theme are to be had not in mere words, but in deeds commensurate with the dignity which is ours as the heirs of a great tradition. We who are of the lineage of these great men do not merely inherit the fame of their accomplishments, but the responsibilities, professional and social, that were theirs. It becomes us, therefore, at this time to determine that by way of expressing our admiration and loyalty to the ideals which they lived to serve, we will, like them, in our lives, exemplify an awareness of a high dedication.

You may wonder in what specific way you can do this sort of thing—and I don't feel qualified personally to tell you. But happily this gathering is being held at a time at which Hallowe'en is not far away, and tonight we are meeting on the evening of All Souls' Day, in that season of the year when spirits stalk abroad.

I don't think it takes much imagination in this banquet hall to be prepared for some rather eerie manifestations. Banquet halls before have been the scene of deep disclosure. You remember Baltasar's feast, when suddenly in the midst of the gaiety, mystical writing appeared on the wall, and it took a Daniel to tell them that the king was found wanting and their very kingdom in danger.

Pierre van Paassen says that in building the walls of the city of Marrakech, the Mohammedans built into their brickwork the bodies of a hundred thousand prisoners, and that they fortified the towers of the gates of the city by throwing into them truckloads of freshly decapitated skulls. And legend has it that on moonlit nights it is possible to hear throughout Marrakech the spectral voices of these eternally imprisoned people, bemoaning their lot.

On times such as this, when men of serious competence and serious purpose are gathered together, it is not impossible to conceive that across the distances of time and the thronging years, voices can be heard, but voices of advice. By leaning lightly to the wind, I think we can hear the voice of Woodrow Wilson, talking to people such as you, men of education and opportunity and potential capability in terms of social leadership; and he says to them, "I cannot admit that you are an educated man merely because you show me your diploma. The only way you can prove it is by showing that your eyes are lifted to some horizon which others less privileged have not been fortunate to see. Unless you carry freight of the spirit, you have not been bred where spirits are bred!" Now that is a call to active, constructive leadership,

* Delivered by invitation at the 7th Fall Clinical Conference of The Medical Society of New Jersey at Jersey City, November 2, 1949. Mr. Nevin is Professor of English and Director of the Department of Speech at Saint Peter's College, Jersey City, N. J.

and it means that those of us who have had the advantages of training, and who therefore emerge with more of the thews and sinews necessary for leadership, should exercise ourselves for the proper attainment. And what are we to do? What can we teach to people? . . . What they had better learn soon, if we are to preserve as much as we now have.

First, a true leadership is compounded of two qualities: of vision and of valor. The man who is the leader has to see clearly to the very core of truth, and then have the courage to defend it, at times against the opposition of popular resentment, but always in the interests of great and common good. He must understand that in man's education, the instruction of the mind at the same time at which the heart is neglected produces only a clever barbarian, more destructive than he whose mind has been neglected. And witness for that truth, the state of the world today! He must teach men that peace comes from an efflorescence of the spirit within the hearts of individuals, and that a man's purpose in life is to achieve that ultimate satisfaction of soul's peace individually, and then share it with others, as a result of his having made not only a good living but a good life. He must teach men that, as in building a home, a nation is built by sacrifice and giving, not by taking. That is how America was built, from the collective strength of those who were giving to it of their strength; and out of that united strength, its greatness emerged! Until we re-establish that principle and reverse the whole tendency of our times, we move in darkness and in danger. We had better teach that truth is more desirable than untruth, that justice is better than injustice, that hope is better than fear, and that love is stronger than hate!

Sometimes, greatness is thrust on people, and the doctors in America are in the van today because they have been the first to bear the insidious attack which is being leveled against the securities which have been ours.

There is another voice that comes to us in this situation. It's a voice that was first heard in the Second Revolutionary Assembly of Virginia. From Richmond it comes across the centuries, with the sound of mounting thunder. It is Patrick Henry saying: "Gentlemen may cry Peace, Peace, but there is no peace. The war is actually begun." What war is this? The same old war that began when Lucifer stood before the throne of God, when evil confronted Incarnate Good, and cried, "I will not serve!" Love triumphed then, when Lucifer was hurled to the depths of hell in which forever since he has been endlessly working; and that same battle now goes on—until all the world is a battlefield and that which is contested for is the very souls of men, the souls of nations, and the very soul of the world. If we lose that battle, we lose our soul, we lose our nation, we lose our civilization! And Henry goes on to say, "Our brethren are already in the field, why stand we here idle? What is it that gentlemen wish?"—to temporize, to procrastinate, to put off?—"What would they have? Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it, Almighty God!"

This is what the Elias J. Marsh Oration commemorates: the spirit of the great men of America, who, going before, have made us the heirs of their generous giving. This is the responsibility that is ours; they have done their job. How well is expressed in words written by one of your own, Dr. John McCrea, in the poem that was the most famous of all those to come out of World War I. Remember, he says in "In Flanders Fields". . .

> We are the dead. Short days ago
> We lived, felt dawn, saw sunset glow.
> Loved and were loved; and now we lie
> In Flanders fields.
>
> Take up our quarrel with the foe!
> To you from failing hands we throw
> The torch. Be yours to hold it high!
> If ye break faith with us who die
> We shall not sleep, though poppies grow
> In Flanders fields.

There isn't much choice. Either this we do, or collectively we fail. We are the living; ours is the strength—ours the purpose—ours should be the consecration. And in this night of spectral voices, let me remind you of yet another thought for us, the living:

> "It is for us, the living, rather to be dedicated here to the unfinished work which they who fought here

have thus far so nobly advanced. It is rather for us to be here dedicated to the great task remaining before us—that from these honored dead we take increased devotion to that cause for which they gave the last full measure of devotion; that we here highly resolve that these dead shall not have died in vain; that this nation, under God, shall have a new birth of freedom; and that government of the people, by the people, for the people, shall not perish from the earth."

This is what I mean when I say we inherit not only the glory of their accomplishments, but the burden of a responsibility which is properly ours as children of a great tradition, as sons of a high lineage.

There isn't too much time left. Nor is there any choice for us, except to fight for these things that mean our very life, except to continue in our effort—but more valiantly and relentlessly—with the same ardors and zeal that those who served the purposes of evil so splendidly illustrate. We should serve the cause of good to the end that we may continue to live for these things that others have died for, and claim them as a heritage to be passed on to our children. Then may it be—and in short time, God willing—that the closing words of the Star Spangled Banner will prove to be highly prophetic:

Oh! thus be it ever when free men shall stand
Between their loved homes and the war's desolation;
Blest with victory and peace, may the heav'n-rescued land
Praise the Pow'r that hath made and preserved us a nation.
Then conquer we must, for our cause it is just;
And this be our motto: "In God is our Trust".
Then the Star Spangled Banner in triumph shall wave
O'er the land of the free and the home of the brave!

Doctors have always taken care of the bodies of people; now something of the great soul of America is, at least partly, in their keeping. May they and may all forward-looking citizens find the inspiration, the unselfish, sacrificial devotion, the power and the strength, to wage relentless war against those things with which we cannot live, to the end that we may continue to enjoy those things without which life is not worth living! That this may be so, and shortly so, humbly, I pray God.

PRIMARY CARCINOMA OF THE TRACHEA SIMULATING BRONCHIAL ASTHMA

J. D. Goldstein, M.D.,* and B. Eisenstein, M.D.,* Jersey City, N. J.

A case of primary squamous cell carcinoma of the trachea is presented in which symptoms not unlike asthma were present. There was apparent response to aminophyllin and epinephrine on two occasions, but with no subsequent response to later medication by those drugs. Clinical diagnosis of progressive obstruction by malignancy rather than asthma was made because of history, findings and poor response to the usual drugs. It would have been desirable to have directly viewed the lesion earlier and institute suitable therapy; however, because of the location and type of tumor, prognosis was poor in any event.

A 65 year old white male was admitted on February 25 with complaints of cough for three weeks. At the onset, this was productive of clear sputum but soon became non-productive. Cough also became constant one week prior to admission. There was a weight loss of 16 pounds in six weeks.

Physical Examination: Temperature was 100.4 and pulse was 88. The patient was an ill-appearing white male with a continuous nonproductive, deep cough causing pain in the left lower chest. The lungs presented some flatness in both upper lobes posteriorly, diffuse wheezing (primarily inspiratory), and rales in the left upper lobe. Admission diagnoses were (1) bilateral tuberculosis and (2) malignancy in the left upper lobe. At fluoroscopy a bilateral thickening of the pleura in addition to a questionable round mass in the upper mediastinum were noted. These findings were not confirmed by x-ray taken the next day. The report of the postero-anterior and left lateral chest x-rays was that there was no evidence of effusion or infiltration. The trachea was in the midline and no widening of the superior mediastinal space was found.

On March 2, he developed two acute attacks of

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dyspnea. For each attack, he received intravenous aminophyllin and adrenalin by hypodermic injection with relief of symptoms. A tentative diagnosis of bronchial asthma was made.

The patient was seen by the senior author on March 4. At that time he was sitting at the bedside in apparent respiratory distress, using his accessory respiratory muscles. A deep persistent cough was present. Standing near the patient, one was able to hear distinct inspiratory wheezes. These were also heard throughout both lung fields, in addition to moist rales at the bases. The patient was given a trial dose of epinephrine with no effect. Bronchoscopy and eosophogram were ordered but before they were accomplished patient's condition became markedly worse. The x-ray revealed bilateral pneumonic consolidation. In spite of antibiotics, oxygen and parenteral fluids, the patient died on March 12.

Laboratory Findings: Blood nonprotein nitrogen was 36; blood sugar was 125. Sputa were all negative for tuberculosis. The sedimentation rate by the Cutler method was 20 and 22 millimeters in 30 and 60 minute periods respectively. Except for one-plus albumen, the urine was normal. The blood count was substantially normal.

Post Mortem Report: Surfaces of pleural cavities were smooth and glistening. Position of lungs was normal. The right lung weighed 925

Dark area in the center of the lesion is due to portion that was removed for microscopic study.

Grams, the left 775 Grams. Four centimeters above the carina in the trachea was a round well circumscribed raised mass 2 centimeters in diameter which almost completely occluded the trachea. The mass extended posteriorly in the septum between the trachea and esophagus, pressing against and displacing the esophagus. It did not involve the mucosa. This lesion in all was about 6 by 4 centimeters, and on cut surface was firm and white. The lymph nodes of the tracheo-bronchial chain were involved, enlarged and filled with firm white material. Both lungs were firm, meaty and dark red. Cut surfaces oozed and were bright red in the upper lobes and dark red in the lower lobes. Pleura were intact, smooth and glistening. Bronchial tree was patent. Pulmonary vessels were clear.

The first tracheal carcinoma was described in 1767. Primary carcinoma of the trachea remains an uncommon diagnosis to date. Stenn[1] reports its observation in 0.004 per cent of all autopsies. The condition was present once in 9000 autopsies at McGill University and once in 12,700 autopsies at the Montreal General Hospital. Both of these cases[2] were squamous cell carcinomas. Lund[1] found two cases in 25,000 autopsies at the Philadelphia General Hospital from 1867 to 1934. In reviewing 433 tracheal tumors reported up to 1938, Culp[2] reports 141 cases of carcinoma. The Mayo Clinic[4] cites 16 cases from 1921 to 1937 and 11 from 1937 to 1945. The case here reported is the first primary squamous cell carcinoma of the trachea in 4500 autopsies from the Jersey City Medical Center.

Maier[6] found this lesion more prevalent in males in a ratio of 2 to 1. D'Aunoy and Zoeller and Bowman reported the same sex distribution. Olsen's series[3] showed 73 males to 43 females which confirms the apparent predilection for the male.

The age incidence[1] varies from 21 to 90, average being 50 years. Maier[6] reports age of onset of carcinoma as being over 50 years, in contra-distinction to papilloma of the trachea which is found more commonly in children.

PATHOLOGY

Gross appearance may vary from a small sessile papilloma growing to an ulcerating fungating mass with tracheal occlusion, or a flat, slow-growing penetrating type of tumor.[1] They may be located in the upper, middle or lower third of the trachea. Commonest site, and least amenable to treatment, is the postero-lateral wall of the lower third of the trachea,[7] and if the lesion is an adeno-carcinoma it nearly always occurs in the lower third.[4] The prevailing histology[2] is that of a squamous cell or adeno-carcinoma in about equal ratio.[3] Cylindromas, which were not found to metastasize, are the next most common group. Hemangioendothelioma, mixed tumors, basal cell carcinoma and malignant adenomas are among

the rarer types[2] of tracheal tumors. The histogenesis of the tracheal carcinomas is thought to be based on protoplasia from the undifferentiated cells of the germinal layer into columnar, goblet or serous cells and by metaplasia into the squamous cell carcinoma. At times the tissue may remain in the basal cell state.[3] Cylindromas take their origin from cells of the mucous glands rather than from surface epithelium.[4] Metastases vary from the highly malignant adeno-carcinoma and squamous cell carcinoma to the non-demonstrably malignant cylindroma. Robin and Mann report only rare metastasies whereas Stenn,[1] Simpson and Moore[3] report over 50 per cent metastatic lesions, usually involving the peritracheal nodes or the esophagus.

CLINICAL FEATURES

The general symptom of weight loss is common. According to Vinson,[8] this was present in 121 out of 140 of tracheo-bronchial tumors. Chills and fever usually denote complications such as, necrosis or obstruction, with secondary infection. Symptoms directly referable to the respiratory tract may vary, depending on the location of the lesion and its effect on the mechanics of gaseous transport through the trachea. This interference may present itself as a stop valve, preventing air from moving in either direction; as a bivalve, decreasing the quantity in both directions or as a check valve, interfering with the ingress or egress of air and causing atelectasis or emphysema. In general, the following symptoms were noted:

Tickling in the throat[1] may be initial symptom.[4]

Dyspnea is the commonest symptom and was initially present in 22 per cent of the Mayo Clinic Cases.[4] It may be paroxysmal, constant, nocturnal or subject to postural changes. It may be progressive and lead to cyanosis if the tumor is obstructing the tracheal lumen.

Wheezing may antedate dyspnea and be present in both phases of respiration which may be heard at some distance from the patient or at the open mouth.[3] A stridor may be heard and can be present whether the lesion is above or below the bifuration of the trachea.[8]

Cough is present in over 50 per cent of the reported cases. It may occur in severe paroxysms leading to acute attacks of suffocation.[6] The cough is usually non-productive at onset but may become productive of frothy sputum and, in about 40 per cent of the cases, be accompanied by hemoptysis.

Hoarseness is noted in about 30 per cent of the cases[4] and is usually due to involvement of the recurrent laryngeal nerve by metastatic, peritracheal lymph nodes.[1]

Dysphagia is found only with involvement of the esophagus.

Distended neck veins are present only with invasion of mediastinum.

LABORATORY PROCEDURES

Fluoroscopy may help visualize mediastinal encroachment or displacement.

X-ray films of the chest in the posterior-anterior and lateral positions may show a diminished tracheal lumen. Tomograms may be of some help. Radiopaque materials in the trachea and esophagus, instilled with caution, are of diagnostic value. Culp[2] reported that x-rays helped in diagnosis in only 2 out of 433 tracheal tumors.

Laryngoscopy may be helpful in the occasional case.

Bronchoscopy is the most useful of all procedures. It was helpful in the diagnosis of 13 out of 16 cases in the Mayo series.[3] It allows for inspection as to location and biopsy as to type.

Smear examination for neoplastic cells may be of value.

DIAGNOSIS, PROGNOSIS AND TREATMENT

When wheezing, paroxysmal cough, dyspnea and clear sputum are present, bronchial asthma must be considered. These symptoms, however, do not rule out malignancy, especially with weight loss, late onset in life and poor response to anti-asthmatic drugs without apparent drug fastness. Suppurative disease of the lungs must also be ruled out when sputum is copious, with and without hemoptysis, fever, and possible weight loss.

Average life expectancy[4] is six months to one year. Cylindroma cases may live for several years. Usual causes of death are obstruction, infection with pneumonia and hemorrhage.[6] Radical surgery is the treatment of choice whenever possible. X-ray, radium and palliative surgery yield only temporary relief.

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Bibliography will appear in authors' reprints

OBSTETRICAL RESPONSIBILITY IN NEONATAL DEATHS *

Alfred Meurlin, M.D., East Orange, N. J.

This analysis of neonatal deaths at Orange Memorial Hospital was begun in January 1949. There have been 24 deaths in the eight months ending August 31. Twelve infants were stillborn, and 12 more died during hospital stay. Total deliveries during this period numbered 1241. Uncorrected neonatal mortality rate is 1.9 per cent. During 1948 there were 1832 deliveries; of these, there were 40 neonatal deaths giving a mortality of 2.18 per cent. Great improvement has been made throughout the country in maternal mortality which, five years ago, was thought to be at an irreducible minimum by some obstetricians. A similar improvement could be made in neonatal deaths. This improvement largely depends upon an increase in our scientific knowledge of the cause and cure of the toxemias of pregnancy and the prevention of premature births.

We do not belittle the care of the premature by the pediatrician or the correction of congenital defects by the surgeon. It is essential for all to work together.

What can obstetricians do to insure normal intrauterine growth and safe atraumatic delivery without hazard to the life and health of the mother?

None of us are so intelligent or skillful that we never make mistakes. It is amazing that in the vast range of scientific knowledge, technical mistakes are few. Fetal losses, however, are frequent, due to our inability to prevent intrauterine deaths which come largely from conditions over which we have no control.

Some premature deliveries, as in placenta praevia, might be carried to viability by courageous expectant treatment and replacement of blood. This applies only to those cases of marginal and partial placenta praevia under close hospital supervision.

Premature fetal births are often indirectly social problems. Supervision of nutrition, metabolism, and disorders of endocrine glands, from the time of adolescence seems a sound basis for eugenics. Some babies should never have been started such as those with definitely hereditary mental and physical abnormalities. These are problems that do not directly affect us as obstetricians, but the agencies working in such fields deserve our support. In a *Study of Infant Mortality* Macdonald[1] states, "the problems of prematurity are twofold comprising first the care of the premature infant and second the prevention of the condition". Prevention of prematurity has not been very successful. Ebbs and his co-workers have studied the effect of nutrition on mother and infant. They observed 380 pregnancies in Toronto. The patients were divided into three groups. In the first group the patients were allowed to continue on their usual diets. The second group was advised to take a balanced diet. In the third group the patients were actually supplied the essential dietary materials. The results are summarized as follows:

	poor diet	*good diet*	*optimum diet*
Abortion			
Prematures			
Stillbirths	17.4%	4.8%	2.2%
Infant mortality first six months ..	72.4%	29.3%	18.6%

A similar study[2] on 5000 women in London resulted in a lowering of the incidence of toxemia by 30 per cent and prematurity 17 per cent.

Birth injuries, although largely cited as a cause of newborn mortality, are not an important factor in this series. No doubt many intracranial injuries are frequently missed even when an autopsy has been performed. Ehrenfest in Davis's *Obstetrics and Gynecology* states, "the term birth injury is void of any meaning to express a diagnosis. Therefore our knowledge could not be obtained from a study of vital statistics, but was gained from a

* Presented at the New Jersey Obstetrical and Gynecologic Society, October 5, 1949.

1. Macdonald, Robert R.: Pennsylvania Medical Journal 48:11, (1945).
2. Parsons, L. G.: Lancet. 1:267 (February 26, 1944).

series of complete necropsies and examination of the cranial cavities in accord with a definite technic. This has reduced the number of deaths heretofore ascribed to asphyxia, prematurity, et cetera."

Obstetricians cannot be held responsible for every birth injury since many occur in rapid spontaneous labors; but we cannot deny that their frequency and extent are, to a large degree, influenced by their judgment and skill.

The most common cause of injury to the contents of the cranial cavity is forcible delivery through a passage too confined for the head. Careful pelvic measurements and a proper relation to the size of the fetal head are essential. Accurate application of forceps to the sides of the baby's head must be observed.

Breech deliveries are especially prone to cranial injury. This is often due to excessive haste or an over-enthusiastic assistant pushing down on the head from above.

Special care should be given to the delivery of premature infants. A generous episiotomy will save the baby's head from pounding on an unyielding perineum. The careful use of outlet forceps is also beneficial. Scott observed, "that the highest death rate in prematures occurred following a short labor with frequent strong contractions of the uterus, with consequent injury to the fetus".

Immediately after delivery energetic measures must be taken to initiate respirations. The most important of these measures is adequate aspiration to ensure an unobstructed flow of air to the lungs. This is particularly important if some fetal asphyxia occurred *in utero* resulting in the aspiration of amniotic fluid.[3]

Philpott and Tweedie[4] state: "Premature labor differs from that of full term in that the lower uterine segment has not thinned normally and must be dilated by painful contractions . . . . causes greater hazards to immature fetus. The second factor is excessive accumulation of organic acids in the blood of the premature. Renal immaturity decreases renal function, liver immaturity decreases liver function. Comparative anemia predisposes to anoxia. Immature lungs often associated with atelectasis predisposes to respiratory infection."

No babies had erythroblastosis in this series. Whether labor should be terminated prematurely in an Rh(—) mother who has blocking antibodies, or whether the woman should be allowed to go to term is still a controversial question. Probably treatment with haptens and transfusions will soon be more widely preferred.

Anemia in the mother lowers the oxygen carrying potential of the fetal circulation. Birth injuries and systemic diseases have a more deleterious effect upon a weak baby. The gravid woman's hemoglobin and blood counts should be frequently checked and when the hemoglobin falls below 10 Grams, adequately treated, and transfusions given if necessary. Another entity previously unrecognized has been described by Wiener.[5] "The hazards to the mother of hemorrhage caused by *abruptio* or *praevia* are well known, but little or no cognizance is taken of the fact that infants born alive in such cases may have dangerous anemia due to occult hemorrhage from the placental or umbilical vessels."

As to systemic diseases, there was a virus pneumonia infection which was responsible here for a double tragedy; both the mother and baby succumbed to an overwhelming infection. Postmortem cesarean was futile due to prematurity and infection.

The effect of analgesia and anesthetics upon the fetus has been emphasized for many years. I shall not labor a point which is so obvious to all of us now. Cole, Kimball, and Daniels[6] have shown that even small amounts of the common analgesic drugs and anesthetics have a definite effect upon fetal oxygenation. They report:

"In elective cesarean section the onset of the infant's respiration was spontaneous in 91.6 per cent of those delivered with spinal anesthesia and 58.4 per cent in those delivered with ether.

Contrasting spinal and ether anesthesia in a series of 108 cases:

	Stillbirths	Asphyxia mild	Asphyxia severe	Delayed respiration
Spinal	0	4.2	4.2	0
Ether	3.4	5.0	23.3	10

3. Lebate, John: American Journal Obstetrics and Gynecology 54:2 (1946).
4. Philpott and Tweedie in American Journal Obstetrics and Gynecology 56:500 (March 1948).
5. Wiener, Alex: American Journal Obstetrics and Gynecology 56:717 (October 1948).
6. Cole, Kimball and Daniels: Journal of the American Medical Association 113:2038 (1939).

The immediate care of the premature infant would still seem to be primarily the obstetrician's concern until the baby can be seen by a pediatrician. Saunders[7] has reported good results in retaining the vernix to reduce heat conduction away from the baby's body. Also gentleness in handling, clearing the air passages by suction and administration of oxygen are essential.

Amnionitis following prolonged rupture of the membranes is a factor in fetal morbidity that should also be considered. The administration of antibiotics and antiseptic perineal care is indicated.

The table shows our record in detail. The causes of death are not greatly different from those reported elsewhere.

Mature obstetrical judgment and an objective analysis of fetal and maternal risks must guide our actions, carefully weighing the danger to the mother and the risk to the baby's life in the balance. Atelectasis is the greatest factor in anoxia. Immaturity is the cause in some instances for a failure of growth of the lung alveoli and their undilatability.

There is a ray of hope in the management of prematurity and abruptio due to toxemias. Not only is a greater effort being made to hospitalize pre-eclamptic cases earlier and treat them adequately, but by the administration of stilbestrol, too rapid aging of the placenta is thought to be avoided.[8]

SUMMARY

We have reported 24 neonatal deaths in 1241 deliveries.

The causes of death were:

Anoxia	12
Immaturity (to 1500 Gms.)	8
Unknown	4
Congenital	3
Trauma	3
Syphilis	1
Enteritis in prematures	1

The obstetrical complications were:

None apparent	9
Abruptio	5
Placenta praevia	3
Toxemic	8
Syphilis	1
Prolapsed cord	1

In two cases there was obstetrical preventability. In case 5, the cause of death was anoxia, intrapartum death due to prolapsed cord. This was a breech presentation in a grav iii, ab i, who came to the hospital on clinic service with a history of ruptured membranes for two days. Labor was desultory. The fetal heart was regular until two hours before delivery. About that time the cord prolapsed and the baby died before it was replaced or delivery effected.

Case 3 was one of abruption with brawny uterus, the significance of which was missed and consultation obtained too late.

TABLE OF DEATHS *

Case	Cause of Death	Died	Gms.	Months	Type of Delivery	Condition of Mother	Grav.	AB.	Para.	Age
1.	Unknown		1)3620		Spont.					
	Macerated fetus (one twin)	S B	2)2560	9	vag.	AP & L/N	VI	III	II	37
2.	Unknown				Spont.					
	Macerated fetus	S B		7	vag.	AP & L/N	I		0	35
3.	Unknown				Vag. del.	Did not attend				
	Ma erated fetus	S B		7	at home	clinic	XIII		XII	33
4.	Immature	S B	420	5	Breech ext.					
					Craniotomy	AP/N	V	I	III	37
5.	Anoxia. Intrapartum death.				Vag.	Premat. Rupt.		I		
	Prolapsed cord	S B	2830	4	Breech	membranes	III	@4		
								mos.	I	28
6.	Deg. and aging placenta					Abruptio				
	Anoxia	S B		9	Cesarean	HGB: 55%	II		I	32
7.	Congenital Patent D.A.				Spont. vag.					
	Patent F. OV.	N B	4030	9.	11 hr. L.	AP/N	IV		III	33

7. Saunders, Colman: Journal of Obstetrics and Gynecology of the British Empire 55:44 (August 1948).

8. Smith, O. Watkins: American Journal Obstetrics and Gynecology 56:821 (November 1948).

Case	Cause of Death	Died	Gms.	Gest. Months	Type of Delivery	Condition of Mother	Grav.	AB.	Para.	Age
8.	Cong. imperforate anus and malformation intest.	N B	2830	9	Easy Breech	AP & L/N	I		0	25
9.	Anoxia. Atelectasis. Prematurity	N B	1330	7½	Cesarean	Cent. Plac. Praevia	III	I	I,d	23
10.	Premature	N B	2000	7	Vag. Induct Rupt. memb.	Partial Plac. Praevia	II		I	35
11.	Anoxia	S B	2830	8	Cesarean	Sep. Plac. Acc. Hem.	VI	III	II	35
12.	Cong. imperforate anus and other malformations	N B		8	Spont. vag.	AP/N	II		I	30
13.	Anoxia. Atelectasis Intracranial Hemorrhage Cord tight around neck. Short umbilical cord.	N B	2620	7	Spont. vag. 3-hr.	Acc. Sep. Placenta AP/N	I		0	25
14.	Immature Necrosis and Deg. Placenta	N B	620	7	Breech	Pre-ecl. Pyelitis	IV		III	29
15.	Atelectasis. Anoxia. Necrosis and Deg. Placenta	S B		7	Del. at home	Del. home Hosp. amb.	I		0	18
16.	Anoxia. Atelectasis Immature	N B	1600	7	Spont. vag.	Toxemia Sep. Plac. Hem.	I		0	24
17.	Anoxia. Toxemia.	N B	1200	6½	Induced. Rupt. Memb.	Toxemia Hosp. 6/da. Pre-labor	II	I	0	29
18.	Anoxia	S B		7½	Post mortem Cesarean	Fatal Virus Pneumonia	III		II	31
19.	Anoxia Atelectasis	S B	2770	8½	Spont. vag.	Entirely normal	IV	I	II	24
20.	Intracranial Hemorr. due to both trauma and prematurity.	N B	2300	7	Forceps. Low ext. Full dil. No progress.	Syphilis undetermined site	II		I	20
21.	Cerebral Hemorrhage into Choroid plexus and rt. lat. ventricle. Immaturity.	N B	720	6	Breech Extraction	Membranes Ruptured for 6 das. AP/N	II		I	37
22.	Premature. Anoxia. Anemia.	N B	1060	6½	Spont. vag.	Plac. Praevia Part. & Succenturiate lobe.	II		I	35
23.	Premature Anoxia	S B	3860	9	Labor 5 hr. Bleeding and Tonic Uterus Cesarean	Abruptio	I		0	25
24.	Premature—died on the 2nd day. Enteritis.	N B	1180	6	Rapid spont. vag. delivery	AP/N	III		II	33

* Abbreviations:
AP—Antepartum
SB—Stillborn

NB—Died in hospital
L—Labor
N—Normal

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SIGNIFICANCE OF RECTAL BLEEDING *

Irving G. Larkey, M.D., Newark, N. J.

Rectal bleeding is a symptom which may accompany a vast variety of conditions. Whether it is of mild or severe degree, whether it is accompanied by related symptoms or not, it is always worthy of investigation because of its possible connotations.

CASE 1

A 33 year old female was being treated for irritable colon. Because of some slight blood streaking in the stool, proctologic examination was advised. Her history was that of having had "gas pains", slight abdominal distention, and the passage of a small amount of blood-streaked mucus for six months. She was apparently in excellent health; there was no weight loss, pain, or abnormal rectal sensations. Examination, however, revealed an indurated ulcer about the size of a quarter, with raised, rolled edges about 2½ inches above the anal outlet on the anterior rectal wall. Biopsy was done and a diagnosis of adeno-carcinoma with infiltration reported. Of interest in this case is the fact that she had received injections for "hemorrhoids" during two periods, seven and five years before.

Most patients when seeing blood in the toilet bowl or on the toilet tissue usually make their own diagnosis of "piles" and frequently go to a drug store for a remedy. Others will make the observation but do nothing about it. Still others become concerned, especially because of the cancer campaign being actively waged through the newspapers, magazines, et cetera, and will report to their doctors.

The type of bleeding is significant, as a diagnosis frequently can be suggested upon evaluation of this symptom. For example, anal fissures usually bleed slightly, and often show only a streak of blood on the toilet tissue, caused by the fissure splitting open upon passage of the stool. Internal hemorrhoids show stress bleeding, and this occurs during the period of straining at stool and may last throughout the bowel movement. Cessation of straining stops this type of bleeding unless the hemorrhoids remain prolapsed. Some of these show blood merely on passing flatus. Blood clots are not usually to be expected in this type of bleeding, as the blood does not lay in the ampulla of the rectum, but passes immediately to the exterior. Blood clots suggest slow, concealed bleeding, as found in an ulcerative process.

It is important to ascertain if the blood is bright red, dark, or black. The closer to the anal outlet that the bleeding occurs, the brighter will be the blood, and vice-versa. It is also important to elicit whether the blood appears to be adhering to the surface of the stool, or whether it is mixed with the stool. It is to be expected that when blood is mixed with the stool, its origin is in the upper portion of the colon; whereas if only coating the stool, it must have originated after the stool was well formed, as in the sigmoid or rectum. Of further interest it is to learn if the bleeding is related to defecation, whether the movement consists only of blood, as would occur in a low level active bleeding area, or whether it merely stains the underclothing. Blood stains on the underclothing, with no relation to bowel movement, are caused by draining abscesses, fistulae, pilonidal disease, thrombosed and ulcerated external hemorrhoids, and other external conditions.

Profuse rectal hemorrhage, resulting in syncope, may occur with carcinoma, polyps, and occasionally with cases of ulcerative colitis.

Rectal bleeding may occur in any age group. In infants and children, it accompanies anal fissures, rectal prolapse, procidentia, intussusception, and rectal and colonic polyps.

CASE 2

A 9 year old girl, whose only symptom was the passing of bright red blood at stool for several weeks, was examined by her physician without the use of instruments. After bleeding continued for several more weeks, he ordered a barium enema. The interpretation of this was inconclusive. No definite diagnosis was made but the child was placed on a low-residue diet. The mother brought the child to my office shortly therafter. Examination

* Read at the surgical staff meeting of the Passaic General Hospital, Nov. 8, 1949.

revealed a friable granular bleeding mucosa, typical of ulcerative colitis, involving the rectum and lower sigmoid, as far as the scope could be passed, all this without any appreciable change in bowel habits or abdominal cramps. Later on, however, diarrhea and cramps developed.

Older individuals have the same conditions as children, and in addition, hemorrhoids, both uncomplicated and thrombotic, condylomata accuminata, cryptitis, the various abscesses in and about the rectum, benign and malignant tumors, specific and nonspecific proctitis and colitis, Meckel's diverticulitis, and the presence of foreign bodies. Certain foreign bodies can produce symptoms with dramatic suddenness.

CASE 3

A middle-aged man who had had symptomatic hemorrhoids for a number of years, while at stool one day, developed a sudden, severe sharp pain in the rectum, accompanied by rather active bleeding. Examination revealed on inspection, protruding and engorged hemorrhoids. Palpation with the finger revealed a hard object partially embedded in one of these hemorrhoids. Upon extraction, it was found to be a sliver of glass measuring 1¼ inches in length by ⅛ inch in diameter. This had been inadvertently swallowed previously.

The procedure to follow on all patients exhibiting evidence of rectal bleeding is a complete proctologic examination, for only by doing this can one be certain of having missed nothing. The examination is composed of four parts.

(1) *Inspection* of the anus and surrounding skin. This portion of the examination may reveal pilonidal disease, condylomata, fistulous openings, pruritus ani, to mention a few.

(2) *Palpation* of the perianal region and digital examination of the anus and rectum. The examining finger should sweep over all aspects of the rectum taking particular care not to miss the hollow of the sacrum, for this portion is blind to visual examination. Palpation externally may reveal areas of induration, fluctuation, cysts, or certain tumors; and digitally, within the anal canal, chronic anal ulcerations, fistulous tracts, hypertrophied anal papillae and intra-rectal masses, as well as extra-rectal masses may be palpated. The condition of the mucous membrane of the rectum may often be judged to be granular as in ulcerative colitis, and of course, foreign bodies and fecal impactions will be discovered.

(3) *Anoscopy* should be performed separately from proctoscopy or sigmoidoscopy as even very large internal hemorrhoids cannot be diagnosed with the sigmoidoscope. The anoscope is first inserted for its entire length of approximately three inches, and then slowly withdrawn, observing the lower rectum for such conditions as internal hemorrhoids; lower down, the dentate line, for hypertrophy of the anal papillae and for infected anal crypts and fistulous openings. This examination is facilitated by the use of a cotton-tipped applicator and a bent probe for probing the crypts and fistulae. Tears at the dentate line and fissures will also be observed.

(4) *Procto-sigmoidoscopy* is probably best carried out with a 10 inch scope for in this last 10 inches of the lower bowel may be found much of the pathology which affects the colon. This procedure can be done without too much inconvenience or discomfort to the patient. There is no other satisfactory way in which this region may be examined. Roentgenologists freely admit that the lower sigmoid, recto-sigmoid, and rectum for the most part are blind areas. Sigmoidoscopy will uncover lesions in this area. Indeed, after the lesion has been discovered, accurate observation will greatly facilitate decisions regarding operability, prognosis and specificity of the disease process.

Too frequently patients are subject to x-ray studies before sigmoidoscopy. If the procedure were reversed, it would be found that many would not require this costly procedure.

The mere finding of definite pathology in the ano-rectum does not obviate the necessity of completing the examination. Approximately 70 per cent of all patients with carcinoma of the rectum also have clinical internal hemorrhoids.

CASE 4

A 52 year old bartender who developed protruding hemorrhoids a year before, had to stop working because of the discomfort. He was able to reduce the protrusion with pressure and hot baths and the use of a proprietory "pile remedy". Eight months after onset of the prolapsing hemorrhoids, he began

to experience continuous dull pain within the rectum and lower sacrum. A month after this, he became constipated and had to resort to laxatives. He then had his first show of bleeding which was slight in amount and continued to the time he presented himself at the rectal clinic. Examination revealed an annular cauliflower-like growth which was almost completely obstructing the rectal lumen.

Many of these patients receive injection treatments and/or operation for hemorrhoids or other ano-rectal pathology because the primary lesion has gone undiagnosed.

CASE 5

A 66 year old man had for 8 months been passing a mixture of dark blood and pus, with associated increased frequency of defecation. He had always been constipated. As long as he could remember, he could not have bowel movements without laxatives. His stools were formed for the most part. Blood clots were passed only at the onset of symptoms and none since. Rectal pain began seven months after onset at which time he first saw a doctor. He was given three hemorrhoidal injections at weekly intervals. The bleeding stopped for a while, although the pain was not influenced. He lost twelve pounds in weight, even though his appetite had not been impaired. The patient was then seen by another physician who operated on him for multiple anal fissures and hemorhoids. He continued being constipated and required more drastic cathartics. Three weeks after the operation, he became obstructed. Further examination and barium enema at this time revealed a complete obstruction at the level of the lowest portion of the sigmoid caused by a fungating adeno-carcinoma.

In conclusion, I should like to emphasize the importance of diagnosis in rectal bleeding so that the major pathologies of the lower bowel may be separated from the minor ones in order that proper treatment may be instituted with the least delay.

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95 Shanley Avenue

MALIGNANCY OF THE THYROID *

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Statistics on the occurrence of thyroid malignancy are misleading unless the reader realizes that there are definite goitre belts, and consequently these variations are mainly geographic. Concerning the overall picture, however, many authorities[1] suggest that this malignancy is more common than is usually supposed. Credit for renewed interest in incidence studies must go to Warren Cole who in 1945 made his first report, and recently has added observations made from 1944 to 1948. The most notable contribution from these studies and those of others has been to emphasize the crucial fact that 90 per cent of thyroid malignancies occur in previously benign nodular goitre, almost always non-toxic nodule, and most frequently solitary nodule (ratio 3 to 1). Moreover, solitary adenomata comprised more than half of all nodular goitres; in addition, almost all of these nodular goitres were of the fetal and embryonal type. Malignancy in diffuse toxic goitre is practically negligible. All investigators concur in this. Hence, if toxic goitre is present, one can almost dismiss completely the possibility of malignancy particularly if toxicity is more than mild. Likewise, the occurrence of malignancy in the toxic adenoma was very infrequent. In the small proportion in whom malignancy was encountered in toxic nodular goitre, the hyperthyroidism was mild.

Another point of agreement[2] is that thyroid malignancy is three times as common in men as in women. Ward and Cole further report that its incidence in men is rising. Arnold Jackson adds that thyroid malignancy is gen-

* Delivered by invitation at the Clinical Conference of The Medical Society of New Jersey, held in Jersey City, November 2, 1949.

1. Including Boyle, Cole, Ward, Rogers, Jackson, Pemberton, Lahey, Ficarra, Black and George Crile, Jr.

2. Particularly among Ward, Cole, Jackson, Lahey, Hare and Warren.

erally becoming more prevalent. The only dissenter is Boyd who still reports that this malignancy is slightly more frequent in women.

The average age of a patient with malignancy of the thyroid is lower than that of patients with other types of malignancy, because it is so common in the young. Kennedy, for example, reported an incidence of 19.3 per cent of thyroid malignancy in children under age 14, with nodular goitre. Dinsmore reported similar figures many years ago. Robertson Ward noted an incidence of 40 per cent malignancy in children with nodular goitre under 15 years of age.

Approximately one half of the malignancies are of the papillary adenoma type or variations of this type. Their degree of malignancy can be graded, and they are generally of only potential, low or moderate malignancy. They are most amenable to present methods of therapy. In this group are the "lateral aberrant thyroid" tumors, whose content shades from normal-appearing thyroid tissue to the papillary adenoma-type of malignancy. Some investigators,[3] believe that these "aberrant" tumors are actually metastatic lesions to regional lymph nodes from a malignancy in the homologous lobe of the thyroid and are practically always of the papillary adenocarcinoma type.

The papillary design of many of these tumors indicates the possibility of good response to roentgen therapy. Lahey reports that 35 per cent of these aberrant nodules are malignant. Both Lahey and Crile, Jr., report that in nearly half the cases of "lateral aberrant thyroid" disease, the homologous thyroid lobe contained histologically indentical tumor tissue. Because in the other cases the thyroid gland itself did *not* contain tumor tissue, Lahey still believes that the origin of the lateral aberrant tumors is in embryonal thyroid cell rests growing in the *ultimo* branchial bodies in the embryo.

Metastases are most frequent in the regional lymph nodes, the lung and the bones, especially the skull. A secondary tumor of these areas should throw suspicion on the thyroid gland. With authorities like Pack, Brunschwig and others advising a relentless attack upon malignancy, primary or metastatic, wherever and whenever it is found, it is probable that in the future even these lesions will not be regarded as hopeless.

The diagnosis of malignancy of the thyroid is not easy and at present will depend largely upon our index of suspicion and biopsy. Symptoms like sudden rapid growth and hardness may be helpful, but the latter also occurs in strumitis or "woody thyroiditis". Other findings like increased pressure phenomena, pain, dyspnea, et cetera, occur just as frequently in benign lesions and are of no diagnostic value. Recent studies[4] on the differential diagnostic value of the rate of conversion of administered inorganic radioactive iodine into protein-bound iodine of plasma have shown that it will be possible accurately to differentiate hyperthyroidism, hypothyroidism and euthyroidism, from non-thyroid states exhibiting alterations of metabolic rate. It is to be hoped that thyroid malignancy which thus far has shown a low rate of absorption of this substance, a therapeutic disappointment, may in the future become detectable by this very test.

Any understanding of the treatment of thyroid malignancy is unfortunately clouded by a bewildering divergence of statistical reports from different clinics of the world. In general, longest survivals and least metastasis were reported in cases in which subtotal lobectomy was performed in the belief that a benign adenoma was being removed, whereas an encapsulated malignancy was actually found. If malignancy is diagnosed or suspected, but no metastases are found, total lobectomy or total thyroidectomy seems to be the treatment of choice. These operations are followed by roentgen therapy by some surgeons. Unfortunately in the statistics on survival rates, the breakdown into these preceding categories is not apparent. In cases with regional metastasis, the preferred treatment appears to be total lobectomy with radical neck dissection *en masse*, the dissection consisting of the removal of the sternocleidomastoid muscle, the internal and external jugular veins, the pre-thyroid

3. Notably Eberts, Clay, Wathwell, Pemberton, Black and King.
4. By Clark, Moe and Adams.

muscles and all the tissues, lymphatic, mascial and areolar, from nuchal line to anterior midline and from clavicle to mandible, including the submaxillary salivary gland and, in some instances, the lower extremity of the parotid gland. Recurrences are treated by roentgen ray by some, excision as they arise by others, or renewed radical dissection by still others. A few surgeons even attack distant metastasis. For the lateral aberrant tumors, Lahey and most other authorities do the homologous total lobectomy and radical neck dissection en masse. Black and a few others do not feel that this is necessary and remove only the aberrant nodules and portions of the thyroid gland involved. Roentgen treatment alone (in addition to being inadequate for long survival) has the disadvantages of causing systemic reactions, local unbearable reactions of the skin, and the local reaction of oppressing edema necessitating the cutting of the pre-thyroid muscles, a procedure which could have been done to more advantage as a part of an adequate operation prior to radiation. The following statistics of results given in terms of proportion of five year survivals are offered for completeness, but to me at least, they have no accurate significance because they are not broken down into comparable categories:

Pemberton	61 %
Horn	55 %
Cole	38 %
Portman	35.5%
DeQervain	17.5%
Dargent	9.6%
Watson and Pool	7.8%

The brightest hope is offered by preventive surgery. Perhaps as in no other organ of the body, malignancy of the thyroid gland is most amenable to prophylaxis. If 90 per cent of thyroid malignancy occurs in previously benign adenoma then removal of the adenomata will eliminate this disease in all but 10 per cent of the cases! Failure to do this promptly must be charged to the physician or to lack of enlightenment of the patient. I have had many patients with adenoma tell me that since their metabolic rates had been reported as normal, therefore, they did not need operation! I have also seen patients who had moved from foreign or American goitre belts, who stated that after living in this area for some time their adenoma had considerably decreased in size and therefore did not need surgical removal.

I cannot improve upon the words of Arnold Jackson who writes:

> "When one stops to consider that one out of every two of these tumors may in time become toxic, that 20 per cent become substernal or intrathoracic and seriously interfere with respiration and embarrass the heart and that one out of five may become malignant, there can appear no logical reason why they should not be removed when first recognized."

When tumors of equivalent size are diagnosed in other parts of the body notably the breast, little time is lost in their removal. Arnold Jackson goes further in describing the Wisconsin goitre prevention program and its possible extension to the American Goitre Association, part of which program is to feed iodine prophylactically to pregnant mothers and to all children.

Removal does *not* mean enucleation. All leading surgeons today urge subtotal lobectomy. This not only affords less likelihood of recurrence of benign adenoma but is, from all reports, adequate treatment for encapsulated malignancy. The mortality and morbidity of this operation in the hands of a good surgeon are practically nil.

As far back as 1931 our moderator, Dr. Frank J. McLoughlin was performing and advocating subtotal lobectomy while some leading metropolitan surgeons were still doing enucleations. Oddly enough he based his practice on the recommendations of William Rienhoff, Jr., that actual or potential toxicity in adenoma was due to the stimulation by the tumor of the glandular tissue surrounding it.

I should like to close with the hope that, for more clarification, pathologists will refine their criteria of malignancy in this gland and that clinicians and surgeons break down their statistics to cover comparable catagories, comparable cases and comparable operations.

609 Bloomfield Street

HYPERSENSITIVENESS TO INSULIN *

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Shortly after the discovery and the widespread use of insulin, physicians became aware of the fact that some patients had already developed a hypersensitiveness to it. As early as 1923, cases were described by Joslin, Gray, and Root.[1]

Since then many excellent reviews and articles have appeared. In 1933, Lasch[2] described a case which he called insulin anaphylaxis. His patient developed urticaria, angioneurotic edema, nausea and vomiting after injection of the smallest amount of insulin. He tried all available brands of insulin. His patient was sensitive to 1/1000 dilution when tested intradermally. The Prausnitz-Küstner transmission test (passive transfer), which I will explain later, was positive. He desensitized his patient by gradually increasing subcutaneous injections. Lasch[3] also reported a case where insulin caused severe anaphylactic reactions. The etiologic role of the albuminoses and peptones in the insulin molecule was demonstrated by a very complete investigation. He desensitized this patient by the subcutaneous method, so that anti-diabetic treatment could be continued.

Ulrich, Hooker, and Smith[4] described a case of allergic reaction to insulin. Their patient was a non-diabetic who was given insulin to gain weight. He developed marked insulin sensitivity. They demonstrated that rapid desensitization is feasible and effective. It may be a life saving measure when immediate and intensive treatment with insulin becomes imperative in such emergencies as coma, or postoperative acidosis.

Another detailed review of insulin hypersensitiveness with the report of an interesting case was given by Estiu and Dumm.[5] They reviewed the subject of insulin allergy and reported a case of insulin hypersensitiveness in a woman who had suffered from bronchial asthma since childhood. They proved hypersensitiveness to insulin and beef by demonstrating transmissible skin sensitizing antibodies to both. They desensitized the patient to insulin, but she developed a putrid lung abscess and died from a fulminant lung hemorrhage.

In spite of the numerous reviews, the discussion of this subject is still timely, in view of the many more cases of insulin sensitivity one encounters, and solution of this problem is still difficult, as I will point out in the protocol of some cases.

INCIDENCE OF HYPERSENSITIVENESS

Insulin sensitivity, especially with generalized reactions, is uncommon. Reviewing diabetic admissions to the Newark Beth Israel Hospital for a ten year period, I could find only 28 patients in whom hypersensitiveness to insulin caused marked local or generalized reactions such as urticaria or angioneurotic edema, joint pains, asthma, et cetera. In the diabetic clinic in a ten year period among 760 patients only four cases of insulin sensitivity were noted. In my private practice, five cases of severe insulin sensitivity were studied. The last case was of unusual severity, and the difficulties that I had in controlling this patient made me look into this problem more fully.

Types of reactions that we usually see are as follows:

1. *Mild local indurations* at the sites of the injections. The areas are red, itchy and slightly sore. They usually appear on the third or fifth day after insulin is started, and they disappear after two or three weeks of continuous use of insulin. This is more common since protamine zinc insulin has been used.
2. *Marked indurations* which appear a few hours after injections. They may be several centimeters in diameter surrounded by a still larger area of erythema. The erythema may eventually involve the entire thigh even down to the leg. These indurations are tender, itchy, and sore. At the site of the injection, blisters with serosanguinous fluid may develop; the glands of the groins may become enlarged and tender. Fever may develop up to 101 or even 102.
3. *Generalized reactions* might be produced, causing urticaria, angioneurotic edema, joint pains, gastro-intestinal symptoms, or asthmatic breathing. In one case, a non-diabetic woman with a negative familial allergic history, was given insulin to increase appetite in order to gain weight. She developed gastro-intestinal symptoms, asthmatic breathing, joint pains, and all kinds of skin rashes. Below I describe a case in which sensitivity to insulin caused marked aggravation of a previous existing asthma.

In some cases there was a history of receiving insulin in the past with interruption for some months or years. In most cases, such histories could not be obtained. In patients

* Read by invitation to the N. J. Diabetes Association, May 24, 1949.

who received insulin on one or more occasions previously, the appearance of local or generalized reactions simulated serum disease. Tuft[6] expressed most clearly the similarity: "Both are acquired or induced forms of hypersensitiveness. In both conditions the reaction does not occur following the initial or sensitizing injection but rather after a variable latent period; and urticaria is present in both as part of the reaction. Also, in both instances following the reaction, positive skin tests to the offending antigens are obtained, and antibodies are detectable in patients' serum:—precipitins and antiphylactins in the case of serum disease, and precipitins and reagins in insulin hypersensitiveness. These antibodies persist in both conditions for only a short time, but cutaneous sensitivity persists apparently for a considerable period of time."

In testing patients with insulin prepared from various species of animals, I found that the reactions are almost identical in most cases. The same reactions are obtained with crystalline insulin. The reaction is due to the insulin molecule and *not* to the animal protein. Every patient was also tested with beef, pork, and some with solutions of protamine and zinc sulphate crystals.

On some of the patients, passive transfer studies were carried out in the following manner. Injections with 0.1 cubic centimeters of the patient's serum were made intracutaneously at several places in the arm of a healthy individual. Forty-eight or seventy-two hours later, 0.05 cubic centimeters of 1/10 dilution of crystalline insulin (U—40) and other insulins were injected at the same sites. Similar injections with similar dilutions of insulin were made on the opposite arm for controls. If a marked (or at least a moderate) reaction appeared at the sensitized sites and none at the controls, it was considered positive. Transmissible reagins or circulating skin sensitizing antibodies against insulin were thus demonstrated.

Eosinophilic studies were done on all patients, but the results varied. Most were within normal limits. No definite conclusions could be drawn from this.

I report below three rather extreme cases which illustrate the difficulties one might have in treating insulin hypersensitiveness.

CASE ONE

A woman, age 39, came to the Newark Beth Israel Hospital clinic in August 1940. She had a typical history of diabetes mellitus with loss of 25 pounds in the past 3 months. Her mother had diabetes. There was a negative familial allergic history. Fasting blood sugar was 243 milligrams, and several specimens of urine contained between 1 and 2.5 per cent of sugar, and no acetone. In view of the marked loss of weight, it was thought advisable to start her on 25 units of protamine zinc insulin and she was also given 1600 calorie diet. She responded excellently, and insulin was reduced to 12 units. She returned eight months later with a reappearance of all symptoms of diabetes. She had discontinued insulin for about six months on her own accord. Blood sugar was now 310 milligrams. Urine showed 3 plus sugar. She was placed on the previous diet with 30 units of protamine zinc insulin. Eight days later she developed general urticaria, angioneurotic edema, and difficulty in breathing. Intradermal test with protamine zinc insulin gave an immediate marked reaction. We tested the patient with four different types of insulin including solutions of zinc sulphate crystals, protamine, beef and pork. All were negative except the insulins which gave almost identical reactions. Passive transfer studies gave definite positive reactions at the transfer sites and none at the controls. Hyposensitization was carried out—starting with 0.5 cubic centimeters of 1/100 dilution. After a struggle of almost two weeks, there was a gradual, but definite decrease in symptoms till the patient was discharged from the hospital. We also used histaminase (Torantil) giving 9 to 12 tablets per day. The patient is now free of allergic manifestations. She is on a mixture of 1½:1 — a total of 36 units of insulin.

CASE TWO

A 36 year old woman was referred to me because of allergic bronchial asthma. There was a positive familial allergic history. She had suffered from asthma in childhood. She was sensitive to grasses, orris root, house dust, and to some foods. She was treated with those extracts and with an autogenous vaccine with fairly good results. One year after the last visit, she was taken ill with generalized malaise, vomiting, and extreme weakness. On the following day she was in a semicomatose condition with intense dehydration. The urine showed 3 per cent sugar with 4 plus acetone and diacetic acid. Blood sugar was 320 milligrams. Carbon dioxide combining power was 32 volumes per cent. In the first 24 hours she required 180 units of regular insulin in divided doses with continuous intravenous infusion of normal saline to correct dehydration and the acidosis. After one week's treatment she was stabilized on a diet of 160 grams of carbohydrates, 70 Grams of proteins, and fats up to 1500 calories, plus insulin 50 units, (protamine zinc in-

sulin 40 units and regular insulin 10 units) before breakfast. Violent asthmatic attacks supervened from the sixth day of treatment. The attacks were so severe that they required frequent injections of epinephrine. The asthmatic attacks started (or were definitely aggravated) a few minutes after insulin injections. The foods to which she was sensitive were eliminated from the diet without appreciable effect on the asthmatic attacks. Intracutaneous test with 0.05 cubic centimeter of crystalline insulin (U — 40) gave a marked plus reaction. It spread almost over the entire arm down to the forearm. Protamine zinc insulin gave the same reaction. Even a dilution of 1/1000 provoked marked reaction. Passive transfer studies with serum of this patient were carried out, and these proved positive. Desensitization was started with 0.05 cubic centimeters of 1/1000 dilution of crystalline insulin. This was given every 15 minutes. After three days of gradually increasing doses, the insulin injections provoked only mild asthmatic attacks of transitory character. After 2½ years we are still struggling with a diabetes which is only fairly controlled on a mixture of 30 units of regular insulin and 15 units of protamine zinc insulin. At times the asthma is still troublesome, but I believe this is not due to insulin.

CASE THREE

A male physician, age 50, has been a mild diabetic for about eight years. Past history is not contributory, except for giant urticaria and angioneurotic edema, on and off, for about one year, 25 years previously. Since then, no other allergic phenomena. In April 1948, he noticed that the diabetic symptoms were slightly but progressively becoming worse. Fasting blood sugar was 220 milligrams. Urine varied from 1 to 2 per cent sugar without acetone. He was advised to take 25 units of protamine zinc insulin. After the fifth day, he noticed induration, redness and soreness with marked itching at the site of the injections. He was advised to use the other thigh. This then became even worse. The erythema spread below the knee joint. It gave the appearance of an erysipeloid inflammation. There was soreness, and later at the site of injection, blisters with serosanguinous fluid. The glands of the groins became markedly enlarged. His temperature fluctuated between 100 and 101. The protamine zinc insulin was changed to crystalline insulin but the reactions were the same. The insulin was then given into the arms with the same results. In fact, additional large urticarial wheals began to appear at the previous sites on the thighs. For a while, giving the injections deeper, using a longer needle seemed to have some beneficial effect—but not for long. Intracutaneous tests were carried out with crystalline insulin, protamine zinc, beef, and pork. A dilution of 1/1000 of crystalline and protamine zinc insulin gave marked reactions. Passive transfer tests were carried out with positive results, proving that the patient was definitely sensitive to insulin. Although at present, it is almost one year that he has been taking a mixture of 25 units (regular 15 units, protamine zinc insulin 10 units) and using a three-quarters-of-an-inch needle for deeper injections, he is still suffering from urticaria almost daily, usually at sites of previous injections. At times he is disturbed because angioneurotic edema and urticaria might occur in any part of the body. To control this, he tried a number of antihistaminic drugs such as: pyribenzamine, neo-antergan, thephorin and trimeton. The last one seems to give the best results. Lately, 25 to 50 milligrams of trimeton in 24 hours seems sufficient to give him comfort. The diabetes is under satisfactory control.

These three cases illustrate the difficulties in treating patients sensitive to insulin.

INSULIN RESISTANCE

By insulin resistance I mean the situation in which an unusual amount of insulin is required in 24 hours to cause a drop in the blood sugar. Cases were reported (and some I encountered) where *thousands of units* were required in 24 hours.

Some conditions usually associated with high insulin requirement are: (1) Diabetic acidosis and coma; (2) Infections and injuries; (3) Liver damage (especially cirrhosis of the liver and hemochromatosis); (4) Endocrine disturbances such as acromegaly, hyperthyroidism and adrenal tumors; (5) Poor absorption (edema, insulin grauloma). When no apparent cause can be discovered for those unusual insulin requirements, we label the patients as "immune to insulin". Immunity is *not* hypersensitiveness. The two are different, not only quantitatively but qualitatively. In insulin allergy, even minute doses cannot be tolerated, because of severe reactions of the skin or mucous membranes or both. Yet, insulin is effective in its specific function of lowering the blood sugar. In insulin immunity, even tremendous doses of insulin are tolerated by the organism, but rendered inefficient in lowering blood sugar, because it is being inactivated by some antibodies. To overcome this, larger and larger doses should be given till those antibodies are exhausted.

Cases have been reported where insulin immunity was preceded by insulin hypersensitiveness.

HYPOSENSITIZATION

I wish to describe the method of hyposensitization I use most often. I start with a higher dilution of insulin with which I obtain a

marked reaction. If the reaction is marked with 1:100 dilution, I start with 0.5 cubic centimeters of 1:1000 dilution. If rapid hyposensitization is required, I give injections every 15 minutes. Otherwise, I give hourly doses for 12 hours daily. Here is the program:

Given in 12 hourly doses per day for 3 days:

1st	dose	1:1000	dilution	0.05 c.c.
2nd	"	"	"	0.1 c.c.
3rd	"	"	"	0.2 c.c.
4th	"	"	"	0.3 c.c.
5th	"	"	"	0.4 c.c.
6th	"	"	"	0.5 c.c.

If it is tolerated I start with the next dilution:

7th	dose	1/100	dilution	0.05 c.c.
8th	"	"	"	0.1 c.c.
9th	"	"	"	0.2 c.c.
10th	"	"	"	0.3 c.c.
11th	"	"	"	0.4 c.c.
12th	"	"	"	0.5 c.c.

If this is tolerated, start with the next dilution (1/10).

13th	dose	1/10	dilution	0.05 c.c.
14th	"	"	"	0.1 c.c.
15th	"	"	"	0.2 c.c.
16th	"	"	"	0.3 c.c.
17th	"	"	"	0.4 c.c.
18th	"	"	"	0.5 c.c.

19th	dose	Concentrate		0.05 c.c.
20th	"	"	"	0.1 c.c.
21st	dose	Concentrate		0.2 c.c.
22nd	"	"	"	0.3 c.c.
23rd	"	"	"	0.4 c.c.
24th	"	"	"	0.5 c.c.

Et cetera.

I use numerous antihistaminic drugs at the same time, as indicated in case 3. However, these are not always helpful.

SUMMARY AND CONCLUSIONS

1. Hypersensitiveness to insulin, although uncommon is a problem in a few patients.

2. It may occur in both atopic and nonatopic persons.

3. Reactions due to hypersensitiveness vary from slight local indurations to generalized reactions.

4. Hypersensitiveness is most often due to the insulin molecule and *not* to the protein species from which it is obtained.

5. Insulin allergy and insulin resistance are not the same immunologic processes.

6. Hyposensitization, by gradually increasing dosage, is successful in many cases of insulin allergy.

7. Antihistaminic drugs are a valuable therapeutic adjuvant in insulin hypersentiveness.

37 Randolph Place

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COSMETICS CAN BE DANGEROUS

The increasing use of cosmetics has resulted in a corresponding increase in skin eruptions due to ingredients in these cosmetics. Francis Whitacre and Rita Parcil presented to the 1950 meeting of the American College of Allergists a list of 120 ingredients now used in cosmetics which were potentially harmful to sensitive patients. The rigid controls of the U. S. Food and Drug Administration were hailed as steps to impo e on the less responsible manufacturers, some sense of their own duty in reducing allergenic factors in the composition of cosmetics.

BLOOD PROCUREMENT

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The increased use of blood in therapy and refinements in blood selection due to the Rh factor, necessitates larger stocks of blood in blood banks than heretofore. It is a great problem, particularly in smaller communities, for hospitals to obtain effective surpluses for their blood banks. Therefore, an organization for blood procurement should be established. For this to function adequately, public cooperation is essential. The medical profession should assume a leading role in creating, organizing and maintaining local and state banks. Therein lies a great opportunity for county medical societies to initiate a worthy public service. "Free blood for every one" has been suggested as a goal. Such a lofty undertaking is impractical on a national basis and one to which we cannot subscribe as long as it shifts responsibility for blood replacement away from where it belongs. Primary responsibility for blood replacement rests on the patient's relatives and friends.

A blood bank must be able to take care of sudden demands, (as when a disaster involves a large group of individuals), and to meet the inroads of blood losses due to accidental contamination, over age in storage, positive serologic tests for syphilis, breakage, et cetera. In addition, some patients do not have relatives and friends to meet replacements. For these reasons many banks require two replacements for each pint administered. Where such a rule can be enforced, effective surpluses will be accumulated. Pint per pint replacement is definitely inadequate. In smaller communities much misunderstanding has resulted when two pints are required and hospitals have been accused of trading in blood.

Experience has shown that when a bank has free access to donations by service clubs and fraternal organizations, these sources are soon imposed upon and before long the donations reach the zero point. In view of this, the following plan was suggested to the Monmouth County Medical Society.

(1) That the disaster committee organize blood donors' associations in each municipality.

(2) That a physician be designated to promote the organization of an association in each community.

(3) That he call a meeting of civic minded individuals, and community and religious leaders to suggest the organization of blood donor associations for the purpose of donating blood in their community.

(4) That there be an annual meeting (sponsored by the county medical society) of all component blood associations, for the purpose of stimulating interest and maintaining organizational continuity.

(5) That the executive officer of the county medical society act as intermediary agent between the blood donors' associations and the blood banks. All requests for blood replacements should be cleared through this office. He should have a list of the designated officers of each of the component associations on whom he would call for blood procurement.

(6) The directors of blood banks agree to continue blood procurement from patients, friends and relatives as heretofore.

(7) The blood donors' associations be responsible for supplying blood in cases of delinquencies in patients from their communities, in case of disaster and for other special reasons.

Comment: Organizing physicians are to be instructed in the operation of blood banks and in the mechanics of blood donations. Pre-donation typing and grouping are not anticipated; once blood is given and processed the donor will receive an acknowledgment card including Rh group, type and blood serology. Donors will arrange for bloodletting with banks at convenient times. Donors will not be bled with a hemoglobin under 85 per cent, nor with a blood pressure under 120 millimeters. A feature of the plan is that donors will be protected from being imposed upon by directors of blood banks, since requests for replacements are cleared through the executive officer of the county medical society who must ascertain that the requests are justified.

Blood banks thus will be insured against depletion of stocks and blood will promptly be issued to patients without waiting for a donation from their friends before the blood is administered. This is a worthy community project, primarily aimed at serving the donors' neighbors. Since lists of donors are not available to the banks, *Donors Anonymous* is suggested as a name for the organization.

Note: The authors welcome comments on the feasibility and desirability of this project.

* From the Laboratories of Fitkin Memorial Hospital, Neptune, N. J.

601 Grand Avenue

THE PROBLEM OF ENDOMETRIOSIS *

Edward N. Bookrajian, M.D., and Roy Morrow, M.D., North Bergen, N. J.

Since the work of Sampson[1] in 1921, endometriosis, (the disease entity characterized by ectopic uterine mucosa) has attained widespread clinical significance and interest. During the intervening years an abundance of information has been accumulated. Despite these tremendous strides, many questions regarding the etiology, pathogenesis and treatment of this disease remain unanswered.

One point is clear. It is increasingly evident that the lesion is more frequently encountered in the practice of gynecology than previously supposed.

The clinical picture presented by endometriosis is so variable, that it can mimic almost any clinical entity peculiar to the lower abdomen and female pelvic cavity. Because of the variable nature of the clinical picture, diagnosis is difficult.

It is because of this relatively frequent incidence, as well as the difficulty encountered in diagnosis that we were prompted to review fifty-six case histories of histologically proved endometriosis and draw attention to a few characteristics of this disease that have not been sufficiently emphasized in the literature.

HISTOGENESIS OF ENDOMETRIOSIS

The etiology of endometriosis remains unsettled though several plausible theories have been advanced. The four chief hypotheses are:

1. Retrograde menstruation—(Sampson 1921).
2. Embryonic theory—(Cullen 1890).
3. Metaplasia theory—(Iwanoff 1898).
4. Lymphatic transportation theory—(Halban 1924).

1. The most widely accepted view is that of Sampson[1] which postulates that the endometrial cells escape by way of the fallopian tubes at menstruation. They are then deposited on the surface of the pelvic viscera and peritoneum, and develop as an implant. This "retrograde menstruation" is favored by anything that hinders the outflow of menstrual blood through the cervical canal, such as cervical stenosis, retroflexion of the uterus, uterine myomata and polyps. Chief objection to this theory is its failure to explain extraperitoneal lesions such as those in the inguinal glands and the umbilicus.

2. The embryonic theory is based on the fact that the epithelium of the pelvic peritoneum, fallopian tubes, uterus, and the germinal epithelium of the ovary are all derived from the celomic mesothelium. Under certain conditions the embryonic rests contained in the pelvic peritoneum reproduce endometrium.

3. The metaplasia theory assumes that since the celomic peritoneum has a common origin, it may be stimulated to form glands resembling endometrium, as a result of inflammation or other trauma such as prolonged hormonal stimulation. Iwanoff, Meyer, Novak,[2] and Meigs[3] have championed this theory.

4. The "lymphatic transportation" theory of Halban has gained impetus since metastatic endometrial tissue have been repeatedly demonstrated in regional lymph nodes. Objection to this theory is that endometriosis of the pelvic lymph glands is a relatively rare phenomenon, and the distribution of endometriosis elsewhere in the pelvic cavity bears no relationship to the anatomic arrangement of the lymphatic system.

It is difficult to explain the mechanism of endometriosis in the various sites that it has been found by any single theory thus far advanced. The prevailing viewpoint is that the histogenesis of all cases is not the same, and that more than one mode of dissemination occurs.

THE AGE FACTOR

The age factor deserves brief consideration. Endometriosis can occur at any age during the

* Read by invitation at the Clinical Conference of The Medical Society of New Jersey held at Jersey City November 2, 1949, under the auspices of the Hudson County Medical Society.

1. Sampson, J. A.: Archives of Surgery, 3:245 (1921).
2. Novak, E.: *Gynecologic and Obstetrical Pathology*. Saunders, Philadelphia, 1947. Second edition, Pages 459 to 475.
3. Meigs, J. V.: Annals of Surgery, 127:795 (1948).

active menstrual life of the female. The youngest case in our series was 18, the oldest 57. Average age was 38.8 years. Our distribution was:

Age	Cases
18 to 20	4
21 to 30	7
31 to 40	19
41 to 50	21
51 to 57	5

FERTILITY AND STERILITY

In the literature, the adverse influence of endometriosis on sterility is frequently stressed. Kelly and Schlademan[4] reported on a large series of cases. Only 46 per cent of these women ever became pregnant. Jenkinson and Brown[5] found 41 per cent, Keene and Kimbrough[6] reported 59 per cent while Meigs[7] found 66 per cent fertility. This adverse relationship did not exist quite as strongly in our series. Of our 56 patients, nine were single and forty-seven married. Thirty-eight of the forty-seven had one or more children, a fertility incidence of 81 per cent. The normal fertility of the married population is generally represented as 88 per cent.

SYMPTOMS

The symptoms of endometriosis are chiefly the result of attempted physiologic activity on the part of Mullerian tissue in an abnormal location. This abnormal implantation, growth and invasion, and most important of all, the menstrual reaction of this ectopic endometrium is responsible for the symptom-complex. Every ectopic endometrial gland is a miniature uterine cavity which may menstruate coincidentally with the uterus. But, for this blood, there is no normal avenue of escape. It follows therefore that the symptoms will manifest themselves most strongly during the period of menstruation. As long as the menstrual function is maintained, the symptoms will tend to progress in intensity. Progress of the disease is ordinarily slow but persistent. Average duration of symptoms prior to surgery in our series was twenty months. The symptomatology in our series corresponds in a general way to that presented in other large groups:

	Number of Cases
Acquired dysmenorrhea	19
Increasing dysmenorrhea	11
Menorrhagia	25
Metrorrhagia	22
Meno-metrorrhagia	14
Low backache	17
Gastro-intestinal disturbance	13
Urinary symptoms	22
Abdominal pain between menses	33
Total Cases	56

While acquired dysmenorrhea is a part of the symptom-complex of many disorders of the female genital organs, it should always lead one to consider endometriosis as a possible cause. Even more important than acquired dysmenorrhea, however, is the symptom of progressively increasing dysmenorrhea. Kelly,[4] Fallon and Moran[8] are among those who state that progressively increasing dysmenorrhea, if present, is pathognomonic of endometriosis. While I do not go to that extreme, I do agree that it is one of the most characteristic and diagnostic symptoms.

Another distinctive clinical feature of endometriosis must be mentioned here because it occurs at or near the termination of the menstrual flow. The patient is suddenly seized with severe lower abdominal pain, greater in intensity than she had experienced during ordinary previous episodes. This pain is associated with marked lower abdominal tenderness, rebound tenderness and rigidity. It is due to rupture of an overdistended endometrial cyst with the extravasated tarry blood causing peritoneal irritation. Unless recognized, the patient will be needlessly subjected to a laparotomy for what appears to be an "acute surgical abdomen". This clinical picture is by no means a rare occurrence and has not received the emphasis in the literature that it deserves.

Menorrhagia, metrorrhagia or a combination of both are fairly constant symptoms. They were present in forty-seven of our cases.

4. Kelly, F. J., and Schlademan, K. R.: Surgery, Gynecology and Obstetrics, 89:317 (1949).
5. Jenkinson, E. L., and Brown, W. J.: Journal of the American Medical Association, 122:349 (1943).
6. Keene, F. E., and Kimbrough, R. A.: Journal of the American Medical Association, 95:1164 (1930).
7. Meigs, J. V.: Surgery, Gynecology and Obstetrics, 89:317 (1949).
8. Fallon, J. *et al.*: New England Journal of Medicine, 235:669 (1946).

However the apparent constancy of these symptoms loses some of its significance when it is noted that eighteen of these cases were associated with uterine myoma.

There is one characteristic of this abnormal bleeding which, when present, is significant. This is a chocolate colored bloody discharge, present directly before and directly after the period, and also at times during the interval phase of the cycle. It is characteristically associated with adenomyosis, the uterine intramural form of endometriosis. With increasing experience, we have learned to regard this symptom as one of the most reliable diagnostic aids, despite the scant attention it has received in the literature.

Low backache associated with the period was present in seventeen cases, but has no particular diagnostic value because this symptom is so frequently associated with other pelvic disorders.

Among the gastro-intestinal disturbances associated with endometriosis, there is one that merits special mention. The triad of pain in the region of the rectum, painful defecation and diarrhea occurring only during the menstrual period is extremely characteristic, when it is present as a recently acquired symptom.

Urinary frequency, urgency and dysuria present no characteristics that distinguish these complaints from the same symptoms found in other pelvic conditions.

While intermenstrual abdominal pain was present in 33 cases in this series its character is extremely variable and presents nothing that would direct one's attention to a possible endometriosis. The amount of pain need not have any direct relationship to the extensiveness of the endometriosis present. Four of our cases with extensive endometriosis complained of no pain whatsoever.

The incidence of fever has not been tabulated because in most of the cases, there was found an associated old pelvic inflammatory disease. However, in two instances, the persistent elevated temperature was not due to any apparent concomitant pathology and promptly subsided a few days after the patients were subjected to surgery. Recently Jeffcoate[9] reported 91 cases of endometriosis in which 9 were associated with elevated temperatures. It should be emphasized, therefore, that a temperature rise can be caused by endometriosis, and unless this is appreciated, the clinician may be led astray in arriving at a diagnosis.

9. Jeffcoate, T. J.: Journal of Obstetrics and Gynecology of the British Empire. 54:858 (1947).

FINDINGS

While endometriosis produces no constant physical signs which can be detected on bimanual examination, there are a few characteristic findings that deserve mention. It has been my observation that in adenomyosis the uterus frequently will be uniformly enlarged and show a marked softening in consistency. This enlargement and softening is so distinctive that it has led me to suspect early pregnancy in many cases, especially when associated with abnormal bleeding.

A recently acquired retroflexed or retroverted uterus that is firmly fixed in position, or a fixed enlarged ovary palpable in the cul-de-sac are significant when pelvic inflammatory disease can be ruled out.

Recto-vaginal examination may reveal a tender, nodular induration in the cul-de-sac or along the uterosacral ligaments, both of which should lead one strongly to suspect endometriosis.

The presence of nodules often of bluish hue, in the umbilicus, laparotomy scars, or the vault of the vagina, and characterized by the increased size, with pain and tenderness at the menstrual periods, offers no diagnostic problem.

The one case of endometriosis of the umbilicus found in this series was diagnosed correctly before operation.

SITE OF THE LESION

The distribution of the lesions in this group follows, in general, that reported in most large series. Our distribution was:

	Number of Cases
Surface of the ovary	20
Adenomyosis (Intramural endometriosis)	17
"Chocolate" cyst of ovary	15
Recto-sigmoid	8
Falloplan tube	6
Cul-de-sac	6
Surface of uterus	4
Broad ligaments	4
Parietal peritoneum	3
Umbilicus	1

Adenomyosis of the uterus and endometriosis of the remaining pelvic peritoneum and viscera do not occur with any degree of frequency concomitantly. While we had 17 cases of adenomyosis and 37 of endometriosis elsewhere, in only two of our patients were both lesions found together.

Endometriosis presents a typical gross appearance at operation. The early lesions (as seen on peritoneal surfaces), consist of small bluish or raspberry-colored pin head sized or somewhat larger cysts. In the advanced stages, puckered areas, due to scar tissue formation, will be characteristic.

The so-called "chocolate" cysts of the ovary, even when small show a strong perforative tendency, causing the ovary to be attached to any contiguous structure such as the posterior surface of the broad ligament or the cul-de-sac. Because of this, when such an ovary is freed from its attachment there occurs a gush of chocolate colored fluid from the cyst cavity.

Adhesions are a frequent and characteristic finding, and when seen should not be confused wih adhesions caused by inflammatory disease. The adhesions of the latter are separated easily by finger dissection whereas endometrial adhesions are dense and firm with complete absence of planes of cleavage. They require sharp dissection if injury to adherent structures is to be avoided.

Endometriosis may extend beyond the serosal surface of the bowel and invade the muscularis of the sigmoid colon and rectum and, rarely, of the small intestine.

In such cases it may be difficult or impossible to differentiate intestinal endometriosis from carcinoma. The points in favor of endometriosis are:

1. Endometrial implants elsewhere in the pelvic cavity.
2. Blood containing cysts in the lesion itself.
3. The absence of enlarged regional mesenteric lymph nodes.

While carcinoma has its origin in the mucosal layer of the bowel, endometriosis rarely invades the mucosa.

TREATMENT

The surgical treatment of endometriosis presents a difficult problem of judgment in most cases. The choice as to the operative procedure must be individualized and several factors should be considered. The age of the patient, the severity of the symptoms, the extent of the lesions, the presence of associated pelvic pathology, and in the final analysis the desires of the patient to remain fertile and maintain her menstrual and sexual functions must all be given proper consideration.

In the group of patients over 45 years, the problem is relatively simple. All of these patients should be subjected to a bilateral salpingo-oophorectomy and hysterectomy if the endometriosis is found in an advanced state, because only by complete castration can the progress of the disease be arrested.

In women between 40 and 45 years, a more conservative attitude should be maintained unless the disease is very extensive. In this age group it is frequently justifiable to salvage an ovary or even a portion of an ovary in order to maintain normal sex function.

In patients under the age of 40, extreme conservatism should be practiced and every effort should be made to preserve ovarian function and the possibility of conception.

Too frequently, however, the extensiveness of the lesion makes conservative surgery impossible. Here is our operative choice:

Hysterectomy with bilateral salpingo-oophorectomy	29
Hysterectomy with unilateral salpingo-oophorectomy	7
Hysterectomy alone	1
Unilateral oophorectomy	15
Bilateral salpingo-oophorectomy	5
Resection of ovaries	8
Lysis of adhesions	14
Uterine suspension	11
Appendectomy	16

In this series it was necessary to do the most radical form of surgery (hysterectomy with bilateral salpingo-oophorectomy) in twenty-nine cases. Twenty-six of these were in the age group over 40. In the remaining eleven cases subjected to hysterectomy, the ages ranged from 32 to 39. In seven of these it was possible to salvage one ovary and, in one additional case, both ovaries were saved. In the remaining three cases the disease was so ex-

tensive that no normal ovarian tissue could be retained, and hysterectomy was done.

Of the five cases subjected to bilateral oophorectomy without hysterectomy, two were under 40. In both, the ovarian pathology was so extensive that no normal ovarian tissue was apparent.

The incidence of necessary radical surgery in this series was 75 per cent. In the larger series reported by Kelly and Schlademan,[4] similar radical surgery was necessary in 74 per cent of their cases.

Lysis of adhesions of more than a minor nature was performed in 14 cases.

Of the 19 cases where hysterectomy was not performed, 11 required uterine suspension.

It can readily be seen from the frequency of radical procedures necessary, that endometriosis is a destructive disease and presents a formidable therapeutic problem, especially in the young female. It should be remembered, however, that these cases are representative of the advanced form of the disease, and that minimal lesions can be treated by medical palliative measures.

Androgens have been used with some success to afford temporary relief, until the objective of pregnancy in the young, and menopause in the older group is attained. Androgens are also useful as a therapeutic diagnostic aid.

Karnacky, Schmitz[10] and others have advocated large doses of estrogenic hormone as a therapeutic measure, despite the fact that this hormone was considered harmful until recently. My own experience with this therapy has been too limited to justify an opinion as to its effectiveness. Irradiation has been recommended by Payne,[11] Schmitz,[10] and others. But I do not think that radiation lends itself as flexibly to the requirements of the individual case as does surgery. To obtain a regression, it would be necessary to use sufficient radiation to destroy ovarian function, for a temporary period at least. This certainly would be an unnecessarily radical form of therapy in most cases.

I am strongly opposed to the use of x-ray or radium in any condition where the diagnosis has not been firmly established. Since it is usually impossible to arrive at a definite diagnosis of endometriosis without laparotomy, it follows that the radiation is indicated only in the occasional case where previous operation has established the diagnosis and further surgery is contra-indicated because of expected technical difficulties or because the patient is a poor surgical risk.

In this series I encountered one such case where x-ray therapy was used, but with disappointing results. Surgery was eventually performed to remove the pain-producing endometrial cyst.

SUMMARY AND CONCLUSION

1. The incidence of endometriosis is higher than previously supposed.

2. Endometriosis can mimic almost any clinical entity that is peculiar to the lower abdomen and female pelvic cavity. It presents a formidable diagnostic problem.

3. A chocolate-colored bloody discharge directly before and directly after a period is one of the most reliable diagnostic signs.

4. Elevated temperature does not rule out the possibility of endometriosis.

5. A uniformily enlarged and softened uterus simulating early pregnancy, is a characteristic physical finding with adenomyosis.

6. Medical treatment (in the form of hormonal therapy) is of value in minimal lesions.

7. Surgical procedures must be carefully individualized, and conservatism must be the keynote in the management of cases where the patient is under forty.

8027 Boulevard

10. Schmitz, H. E., and Towne, J. E.: American Journal of Obstetrics and Gynecology, 55:583 (1948).

11. Payne, F. L.: *Journal of The Medical Society of New Jersey*, 44:496 (1947).

EARLY DIAGNOSIS OF CARCINOMA OF THE BREAST BY CYTOLOGIC TECHNIC

WITH REPORT OF A CASE

Benjamin D. Jacobson, M.D., New Brunswick, N. J.

Until the cause of cancer will have been established, the only method of eradication of a carcinoma is that of early diagnosis, followed by complete destruction of the lesion in its incipiency. Unfortunately early diagnosis is not feasible in most cases.

In certain parts of the body, diagnosis can be achieved by cytologic technics earlier than by other means at our command.

The cytologic characteristics that distinguish malignant cells are macronucleus, hyperchromatism, and polymorphism. The criteria for malignancy depend on the variation from the normal structures in the organs in which cytologic diagnosis is possible: breast, cervix, lungs, stomach, kidney and bladder.

One should, however, not overemphasize the statistical reports on findings with different cytologic technics and staining. The important criterion is whether in a certain number of cases this procedure will enable us to discover cancer and start treatment earlier than would be the case with the usual means at our disposal.

CASE REPORT

A 32 year old woman noticed a swelling of her left breast, accompanied by a cloudy discharge from the nipple six months ago. Her attention was drawn to it by pain and on inspection she saw the nipple discharge. She consulted a surgeon who suggested that the tumor was benign. Another physician examined her later and took a specimen of the secretion from the nipple and spread it on a slide; another specimen was taken from the mass by aspiration and spread on a slide. In all, five slides were prepared and immediately immersed in a solution of equal parts of 95 per cent ethyl alcohol and ether. The pathologist received three slides and examined them, using the routine haematoxylin-eosin stain. I received two slides, one with the nipple discharge and another with the breast aspiration material.

These specimens were subjected to examination with the routine Papanicolaou technic. The cytologic report received from the pathologist was: "Epithelial cells, singly and in clumps, suggestive of duct papilloma, either benign or of a low grade malignancy." My own cytologic report stated: "Malignant cells present, biopsy suggested".

Physical findings: The left breast displays a tumor five centimeters in diameter, situated in the left upper quadrant. The tumor is hard, not freely movable and not attached to the skin or the nipple. The mass is poorly outlined.

Operation: A radical resection of the left breast was done. The pre-operative diagnosis was: benign tumor. Post-operative diagnosis, before the pathologist's examination, was also benign tumor.

Pathologic report: The breast tissue is obscured in a large amount of fat but where resected appears rather abundant and quite densely fibrous. A few areas of unusually firm consistence are seen which cut with gritty character but show no defin-

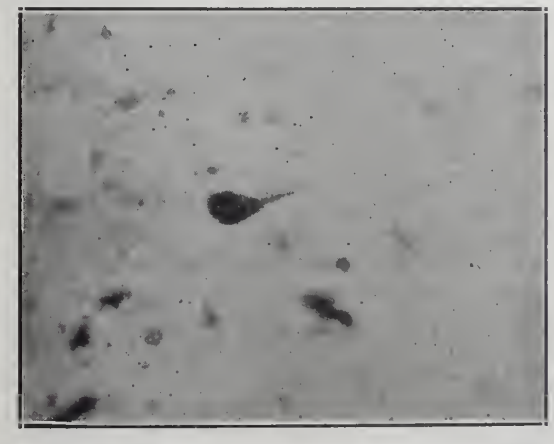

Figure 1. Malignant cell from breast secretion smear.

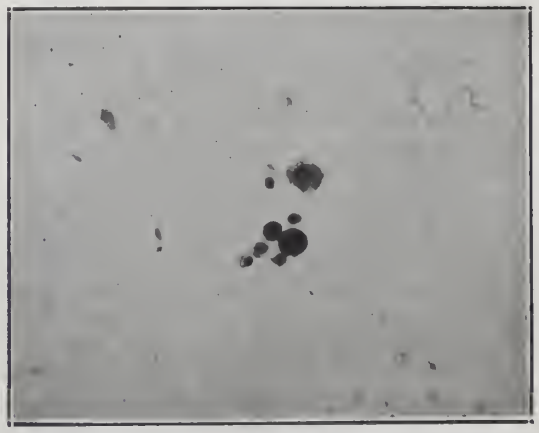

Figure 2. Two malignant cells from breast aspiration smear.

ite tumor. No lymph nodes are discovered in the axillary content. Sections reveal numerous duct-like structures in a rather thick layer of laminated fibrous tissue quite separate from the normal breast stroma. These structures vary considerably in size and in shape; and have varying size lumens, often quite large, filled with desquamated cells or granular eosinophilic secretion. The lining cells are rather immature and small and are clustered in a rich papillary organization which partly fills the lumen. These structures are seen side by side with resting gland tissue of ordinary character or showing some cystic dilation of ducts and some atrophy of glands within a rich, fibrous stroma. An occasional cyst is seen with the latter, filled with necrotic epithelium and surrounded by dense scar. No tumor infiltration is seen extending beyond the limits of the duct already described.

Diagnosis: Non-infiltrating intra-ductal papillary carcinoma (comedo carcinoma). No lymph nodes are involved.

COMMENT

The average duration of a comedo carcinoma, prior to diagnosis, is 18 months. In 36 per cent of the cases, the patients had noted either a serous or sanguinous secretion; or fluid could be expressed from the nipple at the time of the examination.

The case which I have presented was diagnosed within six months after the initial symptoms appeared.

At that time a nipple discharge had already been present. There exists a distinct possibility that a correct (or at least a suggestive) diagnosis might have been made at that earlier time if specimens had been submitted to study by the smear method.

Having decided on the strength of the positive smear to perform a radical operation, the surgeon omitted examination of a frozen section or biopsy material because even the negative outcome of these tests would not have changed his decision.

It is, however, the opinion of Dr. Papanicolaou and other workers in his field that smear examination should not supersede the approved technics. It should serve only as an important aid in the diagnosis of cancer. Being a less disturbing and painless procedure, it will thereby permit of an earlier diagnosis.

SUMMARY

Cytologic technics can be successfully used to diagnose certain cases of early carcinoma of the breast. The test is a simple office procedure, relatively free from discomfort to the patient and easily available to the physician.

A case of proved malignancy discovered by this method is presented.

187 Livingston Avenue

FIFTY YEARS AGO

"It is, I fear, undeniable that the study of psychology, both normal and morbid, is regarded with misgiving, nay, even with aversion by a large proportion of the medical profession. . . I cannot take the view of Clauston that psychiatry should be taught in all medical schools. The intellectual development of the average medical student is not equal to grappling with abstract problems with the ardor and insight that come with later years. For him, the concrete is all. Hence his enthusiasm for things surgical. With the coming up of postgraduate wisdom, and the responsibilities of practice, however, there arise both appreciation and opportunity; and then it is, that a little well directed study will help amazingly." From a paper entitled: "The Diagnosis of Insanity" by J. L. Corning, M.D., read at the 1899 Annual Meeting, The Medical Society of New Jersey, pages 171-172 of the 1899 TRANSACTIONS.

ONE HUNDRED YEARS AGO

FROM THE REPORT OF THE STATE SOCIETY'S WESTERN DISTRICT (1849): "That direful disease, small-pox, with death and distress amongst thousands has providentially been withheld from the immediate vicinity of Burlington, but numerous cases have fallen under the charge of practitioners of our neighboring townships. Among the unvaccinated, the disease assumed its most malignant form, often terminating fatally. Had it not been for the indefatigable exertions of the medical brethren, it might have spread to an alarming extent. Vaccination has been much neglected by the poorer classes and the physicians of our district have expressed a desire for legislation on this point, viz: vaccination among the poorer classes at the expense of the state. Your reporter trusts that the Standing Committee will give this due consideration." (Page 463 of 1849 *Transactions of The Medical Society of New Jersey.)*

STATE ACTIVITIES

HADDON HALL HIGHLIGHTS

As our 184th Annual Meeting rolled into history, the score-board showed a total registration of 1870. This comes within three persons of the all-time high of 1873 recorded in 1948. Particularly gratifying was the registration and attendance of delegates. More than 82 per cent of all delegates elected, came to Haddon Hall for the Annual Meeting. And at the second session, 90 per cent of the registered delegation attended! This is a record that few legislative bodies can equal.

At the annual banquet, instead of bringing in talent from out-of-the-state or out-of-the-profession, we heard the Essex County Doctors' Chorus. And as this unique combination of medical and laryngeal skill harmonized through Haddon Hall, there was general agreement that this was tops in musical entertainment. While the scientific program was serious enough, it was counterpointed by a number of heart-warming social events. There was, for instance, the dinner in honor of Mrs. David Allman, the first New Jerseyite to head up the Woman's Auxiliary to the American Medical Association. The Trustees and their ladies sponsored that one. Each subcommittee to the Welfare Committee had a well-attended dinner meeting, which, as it turned out, proved to be successful on both the organizational and the nutritional fronts. Then, we gave a party to the exhibitors —those long-suffering ladies and gentlemen behind the booths, the ones whose rental helps fuel the convention. Here too, the entertainment was strictly home-grown, most of the performance coming from the exhibitors themselves, who really exhibited some talent at that party.

The scientific sections were also doing business to crowded halls. Average attendance was 143 per meeting which, considering the competing counter-attractions of Alantic City, was something to boast about. The scientific exhibits were eye-catching and brain-stimulating. Most of them were really blue-ribbon projects, but since there was only one first prize in each class, the committee had to do some profound communing before coming up with their awards. This is the way the committee finally worked it out:

Class I: (For original work and excellence of presentation)

1st prize—Congenital Heart Disease, Diagnosis and Treatment

Harrold A. Murray, M.D., William Rumsey, M.D., Charles Bailey, M.D., Daniel F. Downing, M.D., Pediatric Department, St. Michael's Hospital, Newark.

2nd prize—Blood Volume in Surgery

C. Abbott Beling, M.D., William G. Bernhard, M.D., George L. Erdman, M.D., Donald T. Bosch, M.D., Thomas V. Morton, Jr., M.D., Robert I. Siegel, M.D., Ladislav Steffan, M.D., Eleanor Bonner, B.A., Hospital of St. Barnabas, Newark.

3rd prize—Fate of Human Tissue Grafts Transplanted in Humans

Lyndon A. Peer, M.D., and John C. Walker, M.D., Newark.

Honorable Mention—Constrictive Pericarditis

Henry A. Brodkin, M.D., and Marvin C. Becker, M.D., Beth Israel Hospital, Newark.

Class II: (For excellence of presentation)

1st prize—Liver Hyperglycemia and Glycosuria

Carroll M. Leevy, M.D., Jacob C. Fineberg, M.D., Thomas J. White, M.D., Angelo M. Gnassi, M.D., Medical Center, Jersey City.

2nd prize—Diseases of the Anus, Rectum and Sigmoid: Diagnosis and Treatment

Edwin H. Albano, M.D., and Arthur Giffoniello, M.D., Columbus Hospital, Newark.

3rd prize—Lesions of the Endocrine System

Samuel A. Goldberg, M.D., Presbyterian Hospital, Newark.

Honorable Mention—Cytological Diagnosis

Nicholas M. Alter, M.D., R. Chesley, Edward Sattenspiel, M.D., W. Berkhofer, F. Traugott, Margaret Hague Maternity Hospital, Jersey City.

For abstract of activities of House of Delegates, see page 341.

Here's the way the 21 counties shaped up when it came to attendance:

Total Members	County	Delegates Present	Members Present	Total Present
149	Atlantic	10	79	89
365	Bergen	19	14	33
51	Burlington	4	20	24
251	Camden	16	51	67
32	Cape May	3	7	10
70	Cumberland	5	18	23
1307	Essex	70	148	218
44	Gloucester	3	7	10
441	Hudson	31	55	86
26	Hunterdon	3	3	6
253	Mercer	18	50	68
202	Middlesex	10	35	45
177	Monmouth	9	39	48
129	Morris	10	17	27
32	Ocean	1	13	14
454	Passaic	24	31	55
34	Salem	2	3	5
70	Somerset	5	14	19
33	Sussex	3	1	4
435	Union	31	35	66
35	Warren	1	3	4
	Fellows, Officers, Trustees, Councilors	15		15
4590	State Society Total	293	643	936

Physician Guests	48
Physician Scientific Exhibitors	35
TOTAL PHYSICIAN REGISTRATION	1019
Auxiliary Members	357
Visitors	296
Scientific Exhibitors	13
Technical Exhibitors	185
TOTAL REGISTRATION	1870

REGISTRATION, 1948, 1949, 1950

	Physicians	Total
1948	1099	1873
1949	1073	1855
1950	1019	1870

BAR ASSOCIATION OPPOSES COMPULSORY HEALTH INSURANCE

On May 27, 1950, the New Jersey Bar Association adopted a report on S-1679 with particular reference to the compulsory health insurance feature. The Bar Association stated that "the country will have sanctioned socialized medicine if this plan is allowed to take effect and the health professions will be subject to regimentation by all of the state and federal echelons whose duty it will be to administer the program". The plan was further branded as "a serious threat of ultimate destruction of the present American system". It was the final conclusion of the Bar Association that "this program of prepaid national health insurance benefits was not recommended".

The committee which studied the bill was headed by Mr. James D. Carpenter and included four other distinguished New Jersey attorneys: Robert F. Allabough, Edward J. O'Mara, James F. Patten and William H. Speer.

The last sentence of the committee's report was "Your committee unanimously recommends that the proposed bill be not enacted into law".

OBITUARIES

DR. JOSEPH E. ROBERTS, JR.

Dr. Joseph E. Roberts, Jr., former chief radiologist at Cooper Hospital, died in the hospital on June 5, 1950, after a short illness.

Dr. Roberts was born in Camden in 1878 and was graduated from the University of Pennsylvania Medical School in 1903. After an internship at St. Joseph's Hospital in Philadelphia, he headed the x-ray department there for five years. He was a consultant at the Zurbrugg Hospital in Riverside and the Salem County Memorial Hospital in Salem.

Dr. Roberts was a past president of the Camden County Medical Society and the Philadelphia Roentgen Ray Society. He was a diplomate of the American Board of Radiology, a fellow of the American College of Radiology, and a member of the Radiological Society of North America, the International College of Radiology and the Philadelphia College of Physicians.

DR. STANLEY M. McGEEHAN

Dr. Stanley M. McGeehan, Ventnor public health officer, died of a heart attack while playing golf on May 14, 1950.

Dr. McGeehan was born in Hazleton, Pa., in 1894, and moved to Ventnor 19 years ago. He was graduated from Jefferson Medical College in 1919, took a post graduate course in urology at the University of Pensylvania and served his internship at the State Hospital in Hazleton.

He was a member of the American Urological Society and chief of the urology department of Shore Memorial Hospital.

1950 ANNUAL MEETING OF THE HOUSE OF DELEGATES

Abstract

Prepared by EDITH L. MADDEN, Executive Assistant

The verbatim text of the Sessions will be published as a supplement to the August Journal

1. Transactions of 1949 House of Delegates were approved as published in supplement to the August 1949 JOURNAL.

2. Dr. Ira Thorpe Spencer, Woodbridge, was awarded the medal as the outstanding general practitioner in New Jersey for 1950.

3. Reports of Officers (printed and supplemental):

a. President—approved.
b. Treasurer—approved.
c. Secretary—approved.
d. Board of Trustees—approved, including resolutions on Public Health Week, Woman's Auxiliary and New Jersey Plan, and dues exemption amendment to the By-Laws.
e. Judicial Council—approved, including the following recommendations:

(1) That the Judicial Council draw up in consultation with legal counsel, a recommended set of uniform by-laws providing for establishment of county society Judicial Committees. These by-laws will be proposed by the Judicial Council to the several county societies.
(2) That each county society be requested, on receipt of the recommended uniform by-laws, to take whatever steps may be necessary to adopt such by-laws for the county society.
(3) That the proposed judicial amendments to the Constitution and By-Laws of The Medical Society of New Jersey be adopted; recognizing that the proposed amendments cannot become effective until May 1951.

f. Executive Officer—approved.

4. Reports of Special Committees (printed and supplemental):

a. Emergency Education Program—approved.
b. Emergency Medical Services—approved.
c. Military Service—approved.
d. Veterans Liaison—approved.

5. Reports of Standing Committees (printed and supplemental):

a. Finance and Budget—approved including the following recommendations:

(1) That the budget for 1950-51 be $124,640.
(2) That the *per capita* assessment for 1951 be $25.

b. Honorary Membership—approved.
c. Publication—approved.
d. Medical Defense and Insurance—approved, including the following recommendations:

(1) That the committee membership be increased from five to seven members. The necessary amendment to the By-Laws was approved by the House of Delegates: Chapter VIII, Section 12—Committee on Medical Defense and Insurance.

"The Committee on Medical Defense and Insurance shall consist of *seven* members. . . ."

(2) That the State Society communicate with the New Jersey Hospital Association urging that physicians employed by hospitals be covered with some form of insurance, explaining that there is a marked increase in the number of residents, interns and other employed physicians who are not eligible for our medical defense insurance because they are not members of our Society; that these physicians are vulnerable to suits and as doctors should be protected.
(3) That the professional liability contract with the United States Fidelity and Guaranty Company, through Faulhaber & Heard, Inc., be renewed for the ensuing year; and the accident and health policy with the National Casualty Company, through the E. & W. Blanksteen agency, be renewed for the ensuing year.

The House of Delegates further approved the recommendation of the Reference Committee that a campaign of education on the details of insurance be carried on through the *News Letter*.

e. Scientific Work—approved.
f. Woman's Auxiliary Advisory—approved.
g. Annual Meeting—approved, including a recommendation that the 185th annual meeting be held at Haddon Hall, Atlantic City, during the week of May 14, 1951.
h. Scientific Program—approved.
i. Scientific Exhibits—approved.
j. Medical Education—approved.

6. Reports of Welfare and Subcommittees (printed and supplemental):

a. Welfare—approved.
b. Legislation—approved.
c. Medical Practice—approved.
d. Public Health—approved.
The House of Delegates further approved the suggestion of the Reference Committee that the Subcommittee on Public Health might have annual or semi-annual meetings with county

public health chairmen to obtain the cooperation of the county societies in carrying out the recommendations of the Public Health Subcommittee.

e. Public Relations—approved.

7. Reports of Public Health Advisory Committees (printed and supplemental):

a. Adult Disease Control—Recommendations to the Director of the Division of Motor Vehicles, State of New Jersey, tabled.
b. Cancer Control—approved.
c. Cardio-Vascular Diseases—approved.
d. Conservation of Vision and Hearing—approved.
e. Child Health—Referred back to the committee for further study and specific recommendation.
f. Crippled Children—approved.
g. Maternal Welfare—approved.
h. Mental Hygiene—approved.
i. Rural Health—approved. This included the following recommendation: "We urge the county societies to lend better support to their auxiliaries next year in their efforts to continue and expand the rural health program".
j. School Health—approved.
k. Tuberculosis—approved.
The House of Delegates approved the reiteration by the Reference Committee of the action of the House in 1947 when it adopted the seven-point program of the Tuberculosis Committee, the first point of which was "The x-raying of all hospital admissions and clinic cases routinely when feasible"; and further approved the recommendation of the Reference Committee that steps be taken to effect this procedure.
l. Tropical Diseases—approved.
m. Venereal Disease Control—approved.

8. Reports of Medical Practice Advisory Committees (printed and supplemental):

a. Anesthesiology—approved.
b. Contract Practice—approved.
c. Hospital Relationships—approved.
d. Industrial Health and Hygiene—approved.
The House of Delegates approved the suggestion of the Reference Committee that the resume of the proceedings of the Congress on Industrial Health be used as a guide in meeting industrial health problems in New Jersey and that the Committee take steps to implement such a program in New Jersey.
e. Laboratory Medicine—approved.
f. Medical Care of the Indigent—approved.
g. Nursing and Nursing Education—approved.
h. Pharmaceutical Problems—approved.
The House of Delegates approved the recommendation of the Reference Committee that the portion of the report on dispensing of medicines by nurses in physicians' offices and industrial plants be referred to the Committee on Industrial Health and Hygiene for action.
The House of Delegates approved the recommendation of the Reference Committee that the State Society protest to the Pure Food and Drug Administration the open sale of antihistaminics, stating the potential dangers and reactions of the drug.
i. Physical Medicine—approved.
j. Radiology—approved.
k. Workmen's Compensation—approved.

9. Reports of Cooperating Agencies (printed and supplemental):

a. Medical Service Administration—approved including nominations for membership on the Board of Governors.
b. Medical-Surgical Plan — approved including nominations for membership on Board of Trustees of Plan.
c. State Board of Medical Examiners—approved.
d. New Jersey Health Congress—approved.

10. Resolutions:

a. Resolution about the nursing problem offered by the Union County Medical Society was amended and approved by the House of Delegates subject to confirmation after further study by the Board of Trustees.
b. Resolution concerning internships from the Union County Medical Society, was amended and approved.
c. Resolution from the Physicians Post 445 of the American Legion, opposing S-2008 was approved.

11. Election: The panel of candidates submitted by the Nominating Committee were unanimously elected to office.

NEW JERSEY SOCIETY OF PHYSICAL MEDICINE

At the meeting of the New Jersey Society of Physical Medicine on May 24, 1950, the following officers were elected: President—Joseph F. A. RuBacky, M.D., Passaic; Vice-President—Elmer J. Elias, M.D., Trenton; Secretary—James C. Hanrahan, M.D., Elizabeth; Treasurer — Thomas P. McConaghy, M.D., Camden; and Member of Executive Council—Fulton Massengill, M.D., Newark.

BOARD OF TRUSTEES

APRIL 16, 1950

The Board of Trustees held a regular meeting on April 16, 1950. The following actions were taken:

1. Dr. James F. Norton, Dr. Royal A. Schaaf, Dr. Sigurd W. Johnsen and Dr. Harrold A. Murray appointed as "Special Committee on Implementaion of the New Jersey Plan".

2. A pension plan for salaried employees was authorized and appropriation was made to cover the premium for past service and current year's premium.

3. Recommendation was approved that Mrs. Norman M. Scott be paid monthly salary of Dr. Scott for six months.

4. In the future, the *Official List* is to be published in alphabetical form only thus saving one -third to one-half the present publication cost.

5. Transfer of $25,000 from the Surplus Account to the House Reserve Account for future expenses was authorized.

6. The request of Legislative Subcommittee for appropriation for legal services was eliminated from the new budget since the Society has engaged an attorney and all matters requiring legal opinion are to be routed through him.

7. Family sickness and hospital coverage to all employees of the Society was approved and referred to the Finance and Budget Committee with recommendation that provision be made for the first year's premium.

8. Report and recommendations of the Publication Committee for reducing the operating deficit of the JOURNAL were approved as follows:

1. Increase rate for colored advertising from $25 per page to $40 per page.
2. Discontinue provision for free reprints.
3. Increase classified advertisement rate to $3 for first 25 words, and 5c for each additional word beyond 25.
4. Over-all increase in advertising rates of 10 per cent.

9. Request of the Academy of Medicine of Northern New Jersey for a contribution of $500 toward their operating expenses (and for use of the Academy building by the Medical Society committees) was approved.

10. Detailed budget for the fiscal year 1950-51 was approved.

11. Recommendation of the Finance and Budget Committee that *per capita* assessment for 1951 be $25 was concurred in by the Board.

12. The possibility of amending the Medical Practice Act to make the corporate practice of medicine illegal was referred to the Subcommittee on Legislation for study as to the method of amendment and for introduction during the next legislative session.

13. The chairman of the Emergency Medical Service Committee was authorized to represent the Society at the meeting of the A.M.A. Council on National Emergency Medical Service in Chicago.

14. Purchase of 2000 "timers" for distribution to those registering at the Annual Meeting was authorized.

15. The permanent disability clause of HR 6000 was disapproved and the Subcommittee on Legislation was instructed to oppose the proposed amendment to extend health insurance to persons when they reach the age of 55.

16. The Advisory Committee on Laboratory Medicine was instructed to act as a bureau of complaints and the committee chairman will be authorized to write to individual hospital administrators, pathologists and morticians, asking them to consider the *Code of Regulations Concerning Autopsies* and try to live up to it.

17. The Board concurred in the recommendation of the Society's counsel that the Babies-Coit Memorial Hospital in Newark petition the Nursing Board for a hearing and representatives of the Hospital Association and the Medical Society be invited to participate in the hearing and if necessary call witnesses to ascertain the facts before taking action.

18. The Board approved the principle of a plan to provide income tax exemption for expenses incurred by a physician in taking a recognized graduate course; and that the New Jersey delegates to the A.M.A. promote a resolution incorporating the proposal with the request that suitable legislation to accomplish this purpose be promoted in Congress.

19. A state plan for epilepsy (as presented through the Welfare Committee by the Advisory Committee on Mental Hygiene) was approved.*

* See page 346, this JOURNAL.

20. The Board concurred in the recommendation of the Welfare Committee that the Society endorse the Mental Deficiency Meeting sponsored by the New Jersey Parents Group for Retarded Children, Inc., join in its sponsorship and name a representative for the planning committee. Dr. Lewis H. Loeser of Newark was named as the Society's representative to the committee.

21. The Chairmen of the Welfare, Public Health and Public Relations Committees together with the Executive Officer and others to be appointed by the President, will be authorized to conduct Public Health Week some time during 1950.

22. The Board approved, in principle, Diabetes Detection Week as scheduled for November 12 to 18, 1950, and suggested that the New Jersey Diabetes Association be requested to submit to the Society the definite program by June 1 for approval.

23. The Board concurred in the recommendation of the Subcommittee on Public Relations through the Welfare Committee that another state-wide press conference be held in the fall of 1950 and that county medical societies be again urged to hold medical press conferences within each county.

24. A resolution on the death of Dr. Norman M. Scott was adopted.†

25. A permanent committee on Medical-Surgical Plan was authorized to consist of two representatives from each of the following: Hospital Service Plan, Medical-Surgical Plan and The Medical Society of New Jersey. Dr. Norton and Mr. Bryan were appointed by the Chairman as the Society's representatives on this committee.

26. Dr. Ira Thorpe Spencer of Woodbridge is approved as the recipient of the 1950 General Practitioner's Award. The Board approved the recommendation of the committee that the award be discontinued after the current year.

27. The 1950-51 program of the Woman's Auxiliary was referred to the Advisory Committee to the Woman's Auxiliary for study and report.

28. The request of the New Jersey Proctologic Society for a separate section on proctology was referred to the Scientific Program Committee without recommendation.

29. The Advisory Committee on Crippled Children is named as the Medical Advisory Committee to the National Foundation for Infantile Paralysis in response to the request for such a committee by the National Foundation.

30. Dr. Vincent P. Butler, Jersey City, is nominated for election to the Board of Trustees of Hospital Service Plan of New Jersey.

31. Dr. James F. Norton is nominated as the sixth New Jersey Delegate to the A.M.A. for the year 1950. Dr. L. Samuel Sica is nominated as Alternate Delegate for the same term.

32. The Medical Education Committee is authorized to work with the Department of Defense in arranging lectures on the medical aspects of atomic warfare by physicians who attended a special training session at Johns-Hopkins Hospital.

MAY 21, 1950

Regular meeting of the Board of Trustees was held on May 21, 1950, at Haddon Hall, Atlantic City, and the following actions were taken:

1. Dr. Crowe was named as acting chairman of the Board in the absence of the chairman, Dr. Sica, who was ill.

2. Dr. George J. Young, Dr. William F. Costello and Dr. Harrold A. Murray were named as special committee to study requests for exemptions from payment of A.M.A. dues presently in the files and requested to report at the next meeting of the Board.

3. Resolution was adopted expressing appreciation of the services of the Woman's Auxiliary in forwarding the National Educational Campaign in New Jersey and request that these services be continued.

The Board approved the recommendation that the resolution also be sent to National Auxiliary.

Resolution referred to the House of Delegates for consideration and action by that body.

4. The Board approved a resolution on "Public Health Week" requesting county societies to organize local observances of this event and recommending that State and local Health Departments be invited to co-sponsor "Public Health Week" with the assistance of allied professional associations and approved voluntary health organizations as cooperating agencies.

Resolution referred to House of Delegates for consideration and action.

5. The Board approved a resolution requesting:

a. House of Delegate affirmation of formulating and offering to the public the "Proposals for a National Health and Medical Care Program";

† See page 348, this Journal.

b. That the Society pledge its energies and resources to the accomplishment of this program in New Jersey; and

c. That the New Jersey Delegates be authorized and directed to propose this program to the AMA House of Delegates in June, 1950.

The resolution was referred to the House of Delegates for action.

6. The president was authorized to draw up terms of employment of counsel on retainer basis for confirmation by counsel.

7. The report of the Treasurer for the calendar year 1949, and fiscal year ending May 15, 1950, was approved.

8. The Board reaffirmed its action of April 16, 1950, in approving the 1951 per capita assessment of $25.

9. The Finance and Budget Committee reported it had favorably considered the provision for family sickness and hospital coverage to all employees of the Society and had appropriated the necessary amount to cover the first year premium.

The Treasurer was authorized to send a letter to Hospital Service Plan guaranteeing payment of the first month's premium together with the application for policies.

10. The Board approved recommendation that luncheon be served at meetings of the Welfare Committee during 1950-51 and that the Welfare Committee budget account be increased to cover the luncheon expenses.

11. The Fall Clinical Conference was eliminated from the program of the Society and the appropriation for the Conference eliminated from the 1950-51 budget.

12. The Veterans Liaison Committee was discharged with thanks as having fulfilled its job and the budget appropriation was eliminated.

13. The Chairman of the Advisory Committee to the Woman's Auxiliary informed the Board that the Auxiliary program for 1950-51 had been discussed with the members of his Committee and all were in agreement that it be approved.

14. The Board reaffirmed its position of October 23, 1949, designating Dr. Joseph F. Londrigan as the representative of The Medical Society of New Jersey to the State Hospital Advisory Council.

15. The recommendation from the Monmouth County Medical Society for amendment of Section 2, Chapter IX of the By-Laws referred to the House of Delegates without recommendation.

16. The Medical-Surgical Plan informed the Board that Dr. Schaaf and Dr. Borsher would be the representatives of Medical-Surgical Plan on the permanent committee of Medical-Surgical Plan.

The Board was also informed that Mr. Sorg and Mr. Durgom would serve as representatives on the committee from Hospital Service Plan.

17. A resolution was received from the Somerset County Medical Society requesting the State Society to intervene in behalf of the State Village for Epileptics and take steps to assure that the institution obtains sufficient funds from the bond issue or other sources. This was referred to the Commissioner of Institutions and Agencies for reply.

18. Incoming President Crowe was authorized to sign Veterans Administration renewal contract covering medical care to beneficiaries of Veterans Administration for the fiscal year ending June 30, 1951.

19. A resolution from Middlesex County Medical Society restricting sale of anti-histaminic drugs tabled.

20. A proposed program for the Diabetes Detection Drive for 1950 was referred to the Subcommittee on Public Health for consideration.

21. Problems of group practice were referred to Judicial Council.

MAY 24, 1950

A reorganization meeting of the Board of Trustees was held on May 24, 1950, in Atlantic City, and the following actions were taken:

1. Salaried personnel of the State Society were reemployed at the salary figures provided in the 1950-51 budget.

2. The Board approved the recommendation of the Special Committee appointed to consider the matter of exemption from payment of A.M.A. dues "members requesting exemption of payment of the $25. dues to the A.M.A. make direct application to the A.M.A., accompanied by a letter signed by the president and secretary of the county medical society certifying to the reason stated for exemption; a copy of the letter will be sent to the State Offices in Trenton."

The Board instructed the Secretary that a

copy of this action be sent to all county medical secretaries.

3. Since the regulations necessary to put into operation the plan for hearing grievances against physicians are not complete, the Board named the Judicial Council as a special committee with power to consider anything which may arise regarding the plan for hearing grievances during this interim.

The Board requested that the regulations be submitted by the Judicial Council to the Board for approval at its next meeting.

4. An honorarium of one week's salary was authorized to each of the convention staff.

5. There is a recent ruling of the Temporary Disability Benefits Board authorizing chiropractors and limited licensed osteopaths to sign disability certificates for cash disability benefits payments. This is under consideration by the Society's counsel and was referred to the President and Chairman of the Board with power to act.

6. Dr. Allman was unanimously elected as Chairman of the Board of Trustees for 1950-51.

7. Dr. Lance was unanimously reelected as secretary of the Board of Trustees for 1950-51.

8. The secretary was instructed to transmit a letter of thanks to Dr. Sica for his services as Chairman of the Board for 1949-50.

STATE EPILEPSY PLAN

It has been estimated that one person is afflicted with epilepsy in every 200 of the general population. If this is true, there would be over 20,000 epileptics in New Jersey alone. Many epileptic children are excluded from school and many adult epileptics have been unable to get employment because of the lack of public understanding of the disease and an organized approach to the social problems incident to it.

The only institution for epileptics in New Jersey is the State Village at Skillman and its function, at present, is almost entirely custodial. About 75 per cent of all epileptics can lead a normal or near-normal life if treatment is applied and if the public understands their problem. Seizures *can be completely controlled in more than half of all epileptic patients* by adequate treatment with accepted medication. Epilepsy is rarely associated with mental retardation.

The primary objective of an epilepsy program should be to make the public aware that the epileptic person should be treated as an individual and should not be rejected because of his disorder.

DIRECTION OF THE PROGRAM

Upon approval of the program outlined below by The Medical Society of New Jersey, these proposals will be submitted to the New Jersey Chapter of the National Society for Crippled Children and Adults with a request for the financial and personnel aid required to put the program into effect.

To coordinate the interest and resources of all the agencies, public and private, concerned with a state-wide epileptic program, it is proposed first to establish an Advisory Council on the Epileptic Program to comprise representatives of The Medical Society of New Jersey, the New Jersey Chapter of the National Society for Crippled Children and Adults, the State Department of Health, the State Department of Institutions and Agencies, the State Department of Education, the State Department of Labor and Industry, and the State Rehabilitation Commission.

Apart from and in addition to this Council, there would be a Medical Advisory Committee, the members of which would be designated by The Medical Society of New Jersey. All medical policies and any changes in medical policy shall be adopted by the Council only after approval by the Medical Advisory Committee.

The Council would select a coordinator for the entire program, whose salary and approved expenses would be paid by the New Jersey Chapter of the National Society for Crippled Children and Adults, if the program is accepted by that organization. (It may be found preferable, in this connection, to designate the Executive Director of the New Jersey Chapter of the National Society for Crippled Children and Adults as the coordinator for the program with the actual work to be delegated by him to a subordinate, specialized member of his staff.)

THE PROGRAM

1. The coordinator, with the guidance of the Council and Medical Advisory Committee, will enlist cooperation of the medical profession, school authorities, health officers, and employment personnel in developing plans to aid the epileptic and to inform the public and professional groups in the part they can play in helping epileptics to lead normal lives in school, at work or in the community.

2. The coordinator will maintain lists of treatment facilities and of physicians interested in treating epileptic patients. He will compile lists of private schools, camps, and other facilities where epileptics will be accepted. He will maintain an information exchange on employment, education and legal questions concerning the epileptic.

3. The coordinator will be available for consultation with patients, their friends and relatives, for advice on meeting individual or personal problems.

4. The coordinator will cooperate with the Department of Institutions and Agencies and with the Medical Advisory Committee in helping to publicize and promote the use of such central treatment, clinical, and educational services as may be available at Skillman Village.

5. Eventually, it is anticipated that the Medical Advisory Committee will give consideration to the desirability of organizing demonstration clinics operating out of the treatment center at Skillman Village—for instruction and consultation purposes to assist physicians, nurses, teachers, et cetera, in handling problems of their epileptic patients. Treatment will *not* be given at these traveling clinics. Patients would be accepted by the clinic *only on reference by private physicians* and recommendations would be sent directly to those physicians. Arrangements as to engagement of a consultant, fees to be paid, and the relationship with private neurologists would be worked out in advance by the Medical Advisory Committee. A traveling clinic would enter a county only with prior approval of the county medical society. A primary purpose of such traveling clinics would be to provide special services to physicians treating epileptic patients.

6. Special studies would be undertaken by the coordinator, the Council and the Medical Advisory Committee in relation to the educational needs of the epileptic child, the need for vocational rehabilitation and placement of the epileptic adult, and the possible improvements in legal statutes governing epilepsy.

The Advisory Committee on Mental Hygiene has approved the epileptic plan as above presented and recommends its approval by the Welfare Committee and by the Board of Trustees.*

* This plan was drafted by our Advisory Committee on Mental Hygiene. It was approved by the Subcommittee on Public Health on March 12, 1950, by the Welfare Committee on March 19 and by the Trustees on April 16. It follows closely the program which has been in operation in Ohio since 1946. This project has worked successfully in that state and the physicians there are well satisfied with it. In Ohio the financial and personnel requirements of the program were underwritten by the state chapter of the National Society for Crippled Children and Adults.

BOOK REVIEW

Nervous and Neurohumoral Regulation of Intestinal Motility. By W. B. Youmans, M.D. Pp. 129. New York, Interscience Publishers, Inc., 1949. ($4.75)

Dr. Youmans describes the methods of recording intestinal motility, the innervation of the intestine and methods of denervation. Sensitivity to epinephrine is next considered. A discussion follows of various reflexes that have to do with things we see constantly in our own practice, the most common of all effects of gastro-intestinal distension. Next the role of epinephrine and acetycholine is considered as each plays its complicated part in intestinal motility. Although important, this section is not easy reading unless one possesses a good knowledge of recent advances in both physiology and chemistry.

The next four chapters deal with the reflex effects on gastro-intestinal and intestinal motility from stimulation of the peritoneum with irritants, from distending the biliary system, from stimulating the urinary tract, and from feeding experiments. The reasons for the effects produced and the inferences that are drawn are extremely ingenious. The book closes with a chapter dealing with the influences on gastro-intestinal motility from the hypothalamus and from the cortex.

The monograph contains some few illustrations. Considering the subject matter there are only a few instances where more of them would help the reader not too familiar with the more complex physiology described. Excellent summaries are found at the end of each chapter. While there is no index of subject matter, there is a lengthy bibliography for each subject discussed. This book is not for the beginner. It will be difficult reading for any clinician. Dr. Youmans has adequately summarized our most recent knowledge on this most complicated subject. The reviewer must agree with Dr. Alvarez that we are still looking forward to the day when we, like the cardiologists, may have something specific for intestinal muscle disturbances. Unfortunately, we may call too many gastro-intestinal disorders "functional" for want of a better explanation of their physiology, and therefore we must leave many of these cases inadequately treated. It is to Dr. Youmans and the researchers in this field that we look for the future advances in gastroenterology.

Andrew J. V. Klein, M.D.

Additional Book Reviews appear on pages 357 and 358.

RESOLUTION ON THE DEATH OF NORMAN McLEAN SCOTT, M.D.

The untimely loss of Dr. Norman McLean Scott by death on March 30, 1950, was a tragic blow to The Medical Society of New Jersey. As a member of the executive staff of this Society since 1938, Dr. Scott had served us most loyally and competently in many capacities. His logical mind, his executive ability, his administrative background and his professional training and experience combined to enable him to perform the pioneer work in the field of voluntary sickness insurance which he began twelve years ago, laying the foundation of the Medical Service Administration and the Medical-Surgical Plan of New Jersey, which have flourished so satisfactorily under his direction. Unlike so many other medical administrators, he was ever mindful of the ideals and traditions of the medical profession and sought always to maintain them. He gained preeminence in the United States as a medical authority in the field of voluntary sickness insurance and his advice and guidance was constantly being sought by other plans, other state medical societies, and by the American Medical Association itself.

By his contribution to the development and growth of the voluntary sickness insurance movement, he earned great credit and distinction, not only for himself, but also for The Medical Society of New Jersey.

He performed many distinguished services for our Society in other activities, especially by his direction of the procurement and assignment program for medical officers for the armed forces during the recent war and by his work in the field of public relations.

Those of us whose privilege it was to know him intimately loved him for his kindliness and generosity, his consideration for others, his honesty, his intense loyalty, and his unfailing devotion to duty.

Whereas, the Board of Trustees of The Medical Society of New Jersey are fully cognizant of the magnitude of our loss and are aware of the difficulty we shall have in replacing Dr. Scott,

Be It Resolved, that we record our deep appreciation and lasting gratitude for the great contribution made by Dr. Scott to the welfare of The Medical Society of New Jersey; that we commend him for his excellent management of the Medical-Surgical Plan and the Medical Service Administration; that we offer our heartfelt sympathy to Mrs. Scott and her children and that this resolution be spread upon the minutes of this meeting of the Board of Trustees and that a proper copy thereof be transmitted to Mrs. Scott.

AMA ANNOUNCES NATIONAL ADVERTISING PROGRAM

The American Medical Association, by unanimous action of its Board of Trustees and Campaign Coordinating Committee, has given the final "go ahead" signal for a nationwide advertising program which will include three principal media—newspapers, magazines and radio—as a new phase of its campaign in behalf of voluntary health insurance and against socialized medicine. Whitaker and Baxter announce that the campaign will be launched in October.

A total advertising budget of $1,110,000 has been approved by the A.M.A. Board of Trustees, with $560,000 allocated to newspapers, $300,000 to radio and $250,000 to national magazines. The newspaper advertising schedule calls for *blanket-coverage of every daily and weekly newspaper in the United States*—approximately 11,000, in total—and the copy is scheduled to run during the week of October 8. Space reservation will approximate 70 inches (probably 5 x 14) in all papers. Thirty of the leading national magazines, and a score of advertising trade publications, will be included in the magazine program.

The radio advertising program calls for an intensive "spot announcement" campaign, utlizing time on some 300 radio stations, covering every state and Hawaii and Alaska. These too are scheduled for October.

"This is *not* an institutional advertising program," say Whitaker and Baxter. They announce that the "Amercan Medical Association is embarking on a nationwide advertising program for two reasons. First, it is determined to aid in every way possible in increasing the availability of good medical care to the American people through the medium of voluntary health insurance. In that respect, the advertising copy will be designed to make the American people 'health insurance conscious' and to encourage the extension and development of prepaid medical and hospital care as a means of taking the economic shock out of illness. Second, American medicine is determined to alert the people to the danger

of socialized medicine and to the threatening trend toward state socialism in this country. The copy will be designed to sell a commodity, (voluntary health insurance) but not any particular brand or plan. The individual will be encouraged to secure sound coverage in the plan which best suits his individual needs. In its second aspect, the copy will mobilize public opinion in support of a basic American ideal—the principle of individual freedom, as opposed to the alien philosophy of a government-regimented economy."

SUPPLEMENTARY LIST No. 4 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Balter, Abraham W., Veterans Hospital, Lyons (18)
Carey, Joseph, 333 Second st., East Newark (9)
Coleman, William H., 641 Parkway av., Trenton (11)
Cox, Harold C., 208 Stockton st., Hightstown (11)
Crisonino, Philip D., 26 Bentley av., Jersey City (9)
Crooks, William J., III, Clinton (10)
Dowds, Samuel C., 218 Walnut st., Montclair (7)
Duckett, Warren J., 21 Carlton av., Jersey City (9)
Englander, Charles, 41 Hillside av., Newark (7)
Feinman, Samuel E., 917 Summit av., Jersey City(9)
Feleppa, Edward E., 618 Springfield av., Sumnit(20)
Firtel, Saul I., 1060 Broad st., Newark (7)
Gerner, Harry E., 2627 Boulevard, Jersey City (9)
Gilman, Charles M. B., Box 487, Red Bank (7)
Gobel, Stanley J., P.O. Box 284, Bound Brook (12)
Graddick, Lester W., 22 Sussex av., Morristown (14)
Guito, Frank, 626 Mattison av., Asbury Park (13)
Harris, William G., Main st., Mullica Hill (8)
Herradora, Juan R., 2750 Boulevard, Jersey City (9)
Hess, George A., Titusville (11)
Hudson, Howard S., 824 Wesley av., Ocean City (5)
Hughes, Rupert S., Jr., 16 N. Broad st.,Woodbury(8)
Hunter, Harold H., 114 W. Broad st., Paulsboro (8)
Jensen, Grover H., 130 Jewett av., Jersey City (9)
Kelly, Leo J., 216 N. Warren st., Trenton (11)
Kirkwood, Allan S., 53 Union st., Montclair (7)
Klein, Allan, 8628 Boulevard, North Bergen (9)
Kren, Frank, 917 W. State st., Trenton (11)
Levinson, Robert M., 824 S. 12th st., Newark (7)
Luce, Henry A., 40 N. Livingston av., Livingston(7)
Mackowsky, Edwin, 241 Second st., Jersey City (9)
Magee, Alfred, 921 Bergen av., Jersey City (9)
Mason, John T., Jr., 118 Young av., Cedar Grove (7)
Meyer, William, 2128 New York av., Union City (9)
Muller, Joseph H., 867 S. 13th st., Newark (7)
Murphy, Patrick H. W., 27 Jefferson av., Jer. City(9)
Newcomer, Harry S.,1048Wash'gton st.,Cape May(5)
Noto, Philip, 158 Washington pl., Passaic (16)
Pilch, Arthur G., 1 Willard av., Bloomfield (7)
Ridpath, Robert F., 154 E. Spicer av., Wildwood (5)
Robinson, Irving W., 835 W. State st., Trenton (11)
Ruffer, Ralph A., 619 15th st., Union City (9)
Schneckendorf, Samuel J.,179 Harrison av., Jer. C.(9)
Shapiro, Edward E., 750 Avenue C, Bayonne (9)
Simmons, Richard J., 254 First av., Elizabeth (20)
Sooy, L. Thomas, 202 W. Holly av., Pitman (8)
Sottilaro, Joseph J., 1921 Boulevard, Jersey City (9)
Stark, Harry L., 680 Boulevard, Bayonne (9)
Strade, Henry, 113 N. 13th st., Newark (7)
Street, Daniel B., 27 Woodlawn av., Jersey City (9)
Sullivan, Cornelius H.,1 Wash'gton av.,Morrist'n(14)
Weinstock, Michael B., 1 Johnson av., Newark (7)
Wiesler, Howard M., Drawer N, Trenton (11)
Woltz, Sidney, 2206 New York av., Union City (9)
Woolf, Bernhardt H., 41 Hedden ter., Newark (7)
Vaughan, James M., 825 Kalghn av., Camden (4)
Zalewski, Irene J., 181 Paulison av., Passaic (16)
Zapf, Reville D., 100 W. Mantua av., Wenonah (8)

ASSOCIATE MEMBERS

Ackerman, Joseph R.,Fitkln Mem. Hosp.,Nept'ne(13)
Collins, Raymond, 38 Washington st.,East Orange(7)
Dern, Samuel M., 444 School st., Woodbridge (12)
Hawke, Edward K., N. J. State Hosp., Trenton (11)
Tyler, Herman Y., St. Francis Hospital, Trenton(11)
Zarski, Walter, 341 Walnut st., Newark (7)

NEW PROCTOLOGY JOURNAL

Announcement is made of the resumption of the journal of Proctology, a monthly periodical which summarizes the world's work in diseases of the colon and rectum. Dr. Frank S. Forte, a member of The Medical Society of New Jersey, is on the editorial board. Annual subscription is $3.00 and remittance should be forwarded to the Managing Editor of the journal at 122 South Michigan Avenue, Chicago 3.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, April 14, with Dr. M. Browne Holoman, presiding.

Dr. Otto Steinbrocker, associate clinical professor of Medicine, New York University, was the guest speaker. His subject "Current Trends and Problems in the Investigative Therapy of Rheumatoid Arthritis", is one of great interest to the profession and is currently receiving wide publicity in lay publications.

Mr. E. G. Sless of the New Jersey State Board of Pharmacy, spokesman for a committee of the Atlantic County Drug Association, briefly discussed the joint responsibility of physician and druggist in filling narcotic prescriptions.

Mr. Charles Jeffries, director of the County Welfare Board, spoke by request, of the many problems confronting the Old Age Assistance program.

Dr. Charles I. Ware was certified to serve as physician in the Pleasantville Baby Keep-Well Station.

A resume of a communication from the Los Angeles County Physicians Aid Association, referred by the State Society, was read, and ordered filed.

A memorandum from Dr. James F. Norton, president of the State Society requesting formal endorsement of the proposals of the New Jersey's Cooperative National Health Program by each county society was read. Our Society formally endorsed the proposals of the program.

On motion a request from Major Harry L. Dein, M.C., for leave of absence while in military service, was granted.

Dr. Vandenberg, reporting for the Committee for Blood Procurement, stated that the number of donors sent by physicians was entirely inadequate and the plan so far could be considered a failure. The disadvantage of the present method of collecting blood only when the Bloodmobile was in Atlantic City, was discussed by Dr. Nickman. He recommended that the committee discuss with the Red Cross the formation of some plan whereby blood could be collected whenever obtainable.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The final meeting of the 1949-50 season of the *Burlington County Medical Society* was held at Medford Lakes Log Cabin Lodge, on May 11. This was the annual meeting with the Woman's Auxiliary. The entertainment committee arranged an excellent program of music and entertainment. The guest speaker was a well-known local resident of the County, Senator J. Mercer Davis, Jr.

The business meeting was short. The president announced that Dr. Freeman W. Metzer was to represent the County Society to cooperate with Red Cross in its effort to determine the facilities available in the County in case of disaster.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The final meeting of the 1949-1950 season of *The Camden County Medical Society* was held on May 2, at the Dispensary Building with Dr. A. M. K. Maldeis presiding.

Drs. John M. Kimmick and Cornelius Regan were introduced to the Society after taking the oath of membership and signing the roll book.

Dr. W. T. Read, Jr., reporting for the Executive Committee, reported that this committee at its last meeting proposed three recommendations. First, that Mr. Eckman be rehired as Public Relations Council, Editor of the Bulletin and Executive Secretary of the Society. Second, that the Medical Defense Committee be expanded to include a Grievance Committee, and that the names of the members be kept anonymous. Third, that the Camden County Nurses Association be allowed to use space in the Dispensary Building for a nurses registration office. All three of these recomendations were passed by the Society.

Dr. H. K. Eynon, chairman of the Nominating Committee, presented the nominations for officers and committees for the year 1950-1951—all of whom were unanimously elected by the Society: *President*, Dr. O. R. Kline; *President-Elect*, Dr. Walter A. Crist; *Vice-President*, Dr. Martin H. Collier; *Recording Secretary*, Dr. William Braun; *Treasurer*, Dr. Kenneth L. Athey; *Historian*, Dr. Helen F. Schrack; *Reporter*, Dr. L. G. McAfoos, Jr.; *Trustee*, Dr. Elliott C. Shull; *Censor*, Dr. A. M. K. Maldeis.

Dr. Maldeis swore in the new officers and presented a review of the various activities of the Society during the past year. This review was in the form of a report which was sent to the State Society. The chair was then turned over to Dr. Oram R. Kline.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

At the annual meeting of the *Cumberland County Medical Society*, which was held April 11, at Richards Farm, Dr. Carl N. Ware of Shiloh was elected to succeed Dr. Anthony Pino as president.

Other offices as recommended by the nominating committee were filled as follows: President-Elect, Dr. E. C. Greene; Secretary, Dr. Mary Bacon; Treasurer, Dr. H. H. Wilson; Reporter, Dr. Norman W. Henry; Executive Committee, Drs. A. B. Kump, Kenneth E. Corson and Robert C. Brown; Censor, Dr. L. J. Kaufmann; Delegates to State Convention, Drs. Ware and Charles Cunningham; Alternates, Drs. H. W. Hendrickson and N. E. Marchione; Nominating Committee, Dr. Kump; Alternate, Dr. Cunningham.

In recognition of many years of faithful and distinguished service, it was decided to honor Dr. Charles W. Wilson of Vineland and Dr. Harry E. Lore of Cedarville by making them members emeri-

tus. Dr. Wilson expressed his appreciation of the honor but stated that he wished to remain an active member of the organization, and the members conceded to his wish.

Dr. Ware introduced James Bryan, executive officer of the state society, who spoke briefly on matters which the state executives wish to present to the county society members.

ESSEX COUNTY

Frank S. Forte, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held on April 13, in the Academy of Medicine, Newark.

The routine society business was covered and the president, Dr. Joseph I. Echikson, then presented the guest speaker of the evening, Senator McClellan (D., Ark.). The Senator gave a memorable talk on trends of the times. For those, who were there it shall be long remembered. For those who were unable to attend it was a distinct loss. His urgent message was not only well received but brought everyone to his feet in a rising vote of thanks.

Another event of great interest was held on April 12. This was the benefit concert for The Essex County Service for the Chronically Ill, given by the Doctors' Chorus of the Essex County Medical Society. It was held in the auditorium of the Mutual Benefit Life Insurance Co., Newark. Under the leadership of Carl Wiesmann the chorus assisted by Dr. Edwin A. Seidman at the piano gave a splendid performance.

High-lights of the concerts were the singing of Dr. Domenico Lupo, a light tenor, and Miss Catherine McGuigan, a pleasing soprano. Additional solos were sung by Drs. Hurve J. Rachal, Daniel E. Kavanaugh, and Ernest Gennell.

Dr. William H. Hahn made a brief statement in behalf of the Essex County Service for the Chronically Ill.

Dr. Daniel E. Kavanaugh, president of the Chorus should be commended for his untiring efforts in keeping the group together.

On April 20, a meeting was sponsored by the Essex County Medical Society at the Hotel Suburban, East Orange. To this meeting were invited both medical and lay leaders interested in problems of tuberculosis control in Essex County as it applies to the general hospitals and other institutions.

The meeting was opened by Dr. Joseph I. Echikson and then turned over to Dr. Kenneth E. Gardner, chairman of our Society's Public Health Committee.

An active round table discussion took place bringing forth many ideas which when crystalized and brought to fruition should be of great benefit to our tuberculosis patients.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

J. Paul Burkett, M.D., presided as the *Gloucester County Medical Society* met at the Woodbury Country Club, on April 20. The most important of the committee reports was the following submitted by Chester I. Ulmer, M.D., chairman of the Public Relations Committee: "For some time, members of the Gloucester County Medical Society have observed the encroachment of the private practice of medicine by certain industrial plants in our county. It frequently occurs that patients who are under treatment by private physicians find their way to the plant hospitals where they are readily accepted for medical treatment by the plant doctor. Chronic diseases which have no relation to occupation or industry, such as rheumatism and arthritis, are treated at plant hospitals. Diathermy is freely available; penicillin is given without charge. A hemorrhoidectomy was recently performed at one of the industrial hospitals. It is also noted that industrial nurses often treat employees in the absence of the plant physicians. There is considerable unsupervised dispensing of medicines by nurses, particularly the sulfa drugs, antihistaminics, codeine cough syrups, etc. Indeed, nurses in our industrial plants practice a great deal of medicine. The corporate practice of medicine is steadily increasing. It is infringing on the private practice of medicine and measures should be taken to check it." After discussion by the society it was decided to submit the matter to the Medical Practice Committee of the State Society at the coming Annual Meeting.

Dr. Burkett appointed Drs. Ulmer, Hughes and Collins to the nominating committee, the May meeting being the time of the election of officers, et cetera.

Dr. Fred Faux then introduced the speaker of the evening, Robert C. McElroy, M.D., associate in Obstetrics and Gynecology at the University of Pennsylvania. Dr. McElroy's topic was "Obstetric Problems and Their Management".

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its seventh regular monthly meeting at Murdoch Hall, on April 4, with Dr. Vincent P. Butler presiding.

The following were elected to membership: Dr. Martin J. MacDonnell of North Bergen and Dr. Francis J. Mara of Jersey City.

Dr. Samuel A. Thompson, professor of Surgery, New York Medical College was the guest speaker. His subject was *The Surgical Rehabilitation of the Coronary Cripple.* (Illustrated)

Discussants were Drs. Halligan, Bortone, Bresev, Leevy, Ginsberg, Marshall, Gleeson and Stockfisch.

Following the scientific session, the meeting was addressed by the executive officer of The Medical Society of New Jersey, Mr. James E. Bryan. Mr. Bryan reviewed the program of the State Society during the past year and asked for the continued cooperation of the county societies in the important period that lies ahead.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

The largest attendance of Hunterdon County physicians ever assembled in one place gathered

at the Clinton House on April 25, to participate in the Annual Meeting of the *Hunterdon County Medical Society*. Tally showed that 88 per cent of the members were present.* Principal speaker was Mr. James E. Bryan, executive officer of The Medical Society of New Jersey who spoke on the New Jersey Plan. The judicial councilor for the area, our own Barclay S. Fuhrmann then discussed the plan for setting up several echelons of grievance-hearing tribunals so that laymen and nonmembers generally would have some forum in which to present any grievances, real or fancied, against individual physicians. The executive committee of the Hunterdon County Medical Society was named by the chairman, Dr. John Fuhrmann as an *ad hoc* committee to explore the possibility of amending our by-laws to provide the necessary county-level machinery to implement the proposed arrangement.

The following were elected to office for the 1950-51 term: *President,* Lloyd A. Hamilton; *President-Elect,* Aurelius J. Bambara; *Vice-President,* Mehran W. Looloian; *Secretary,* John B. Fuhrmann; *Treasurer,* Barclay S. Fuhrmann. Dr. Barclay S. Fuhrmann was designated as our representative to the state nominating committee with Dr. Hamilton as his alternate. To the state House of Delegates, Dr. Arthur Jenkins and Dr. John Fritz were named delegate and alternate respectively.

The Society voted to purchase liability insurance furnishing protection against libel, slander and defamation actions against the organization or any officials speaking on its behalf.

MIDDLESEX COUNTY

Martha F. Leonard, M.D., Reporter

A joint meeting of the *Middlesex County Medical Society* and the Middlesex County Pharmaceutical Society was presided over by Dr. H. P. Fine at the Roosevelt Hospital, April 20.

Dr. C. Robert Hardy of New Brunswick was elected to Associate membership.

Dr. Ira T. Spencer of Woodbridge was selected as this county's candidate for practitioner of the year. The Society voted to go on record as sponsoring the New Jersey twelve-point program of voluntary health insurance. Action concerning one member delinquent in paying dues for three years was deferred pending a personal interview with this member in the hope of arranging retirement from the Society in good standing. It was voted by the Society to submit to the State Society Dr. Kler's statement opposing over-the-counter sales of antihistamine drugs. Plans for formation of a county committee for atomic defense were tabled since a meeting is being planned for a national committee with representatives of the State Societies.

A report was given of the meeting of the trustees with the delegates and alternates to the State Convention. Ways were discussed to enhance the influence of Middlesex County by having members on the Reference Committee on some of the standing committees of the State Society and by presenting a candidate for the presidency. The Society approved the suggestion to engage a suite at the Convention hotel for the president's use and for meeting purposes. In accordance with a suggestion from the State Society it was voted that this county introduce the suggestion to the House of Delegates that American Medical Association dues be collectible for the State through individual county societies. It was noted that failure to pay American Medical Association dues would result in termination of membership in the American Medical Association, but would not affect county and state membership.

Dr. Sidney Becker reported for the Pharmaceutical Liaison Committee. A plan is under way to compile a list of common drugs, mixtures, and prescriptions for distribution to physicians, similar to the New Jersey Formulary.

Dr. Fine introduced Dr. Kochek, president of the County Pharmaceutical Society, who informed the physicians of the survey by the Federal Drug Administration and stressed that most prescriptions cannot be refilled without specific request by the physician.

The speaker of the evening was Mr. William Colgate, director of Professional Service Training for E. R. Squibb and Sons, New York, who spoke on "Recent Studies in Vitamin B-12".

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The annual meeting of the *Passaic County Medical Society* was held at the Woman's Club, Paterson, May 16, with Irving Okin, M.D., the retiring president, presiding.

Dr. Okin read the following resolution on the death of Dr. John S. Yates:

> Whereas: The Almighty God in His Infinite Wisdom, has deemed it best to take from our midst, John S. Yates, devoted physician, faithful friend and respected citizen and
>
> Whereas: The Officers and Members of the Passaic County Medical Society feel that the loss of so fine a resident and colleague will be keenly felt by all with whom he came in contact through many years of service and a well spent life—
>
> Be It Resolved: that the Passaic County Medical Society will long remember Doctor Yates for his devoted loyalty to his patients, his colleagues and his friends and
>
> Be It Further Resolved: that this Resolution be inscribed in full upon the minutes of this meeting and that a suitable copy thereof be presented to his family.

The following slate presented by the Nominating Committee was unanimously elected: President, John E. Leach, M.D.: First Vice-President, Sandor A. Levinsohn, M.D.; Second Vice-President, Joseph M. Keating, M.D.: Secretary, Floyd Fortuin, M.D.; Treasurer, Theodore K. Graham, M.D.; Reporter, Leopold E. Thron, M.D.: Board of Censors (3 years) Irving Okin, M.D.

Dr. George E. Murphy of Ridgewood was elected

* Can any society, large or small, match that ratio of attendance? The editor would like to know.

to Active membership in the Society and DR. OSCAR E. GOLDSTEIN of Passaic, DR. JOSEPH M. DE LUCA, St. Joseph's Hospital, DR. PETER D. CARRAS of Paterson were elected to Associate membership.

Upon motion duly made, seconded, and unanimously carried, the following Resolution was adopted:

> RESOLVED, that the members of the Passaic County Medical Society, a non-profit corporation of New Jersey, do hereby resolve and declare it advisable to, and hereby amend the present Constitution and By-Laws of the Society to read as indicated in the "By-Laws of Passaic County Medical Society" presented to this meeting; and that a copy of such By-Laws be attached to and made a part of the minutes of this meeting.

Following the close of the business session, Dr. Okin introuced MR. C. H. GILMAN, Deputy Director, Treasury Department, U. S. Savings Bonds Division, who briefly addressed the members on the advantages of the bond-a-month plan and the value of building an annuity through savings bonds.

Dr. Okin then introduced our new president, Dr. Leach. Dr. Leach congratulated Dr. Okin on the progress made during his fine administration and stated that he will do his best, when he takes office June 1, and thanked the Society for the honor conferred upon him.

The scientific session speaker of the evening, OTTO STEINBROCKER, M.D., was introduced by Dr. Okin. Dr. Steinbrocker's subject—"Clinical Observations and Problems in the Treatment of Arthritis and Related Conditions with ACTH and Steroids" was illustrated with lantern slides. His lecture was very well presented and exceptionally interesting and educational. Dr. Steinbrocker is chief of Arthritis Service at the Hospital for Joint Diseases; chief, Arthritis Clinic, Lenox Hill Hospital, associate clinical professor of Medicine at New York University Medical School.

Dr. Okin expressed his thanks and appreciation to the officers and members for their interest and participation in the affairs of the Society during his administration.

SALEM COUNTY

John S. Madara, M.D., Reporter

On May 6, at 3 p. m., the annual shad dinner of the *Salem County Medical Society* was held at the Salem Country Club.

This year the purpose of the meeting was for the doctors of Salem County to "meet the press". The editors of all the newspapers of Salem County and their wives were invited to the dinner. Those attending were: Mr. William B. Dunn of the *Salem Standard and Jerseyman;* Mr. and Mrs. Thomas Summerill and Mr. and Mrs. Carl Stauffer of the *Penns Grove Record;* Mr. and Mrs. Charles Smith of the Woodstown *Monitor-Register* and *Salem Sunbeam;* Mr. and Mrs. Lewis Ballinger of the Wilmington *Journal-Every Evening;* and Mr. and Mrs. Preston E. Foster of the *Elmer Times.*

Following the dinner, the meeting was called to order by the new president of the society, DR. AUGUST JONAS of Salem, who turned the discussion period over to DR. JOHN S. MADARA. Among the topics discussed by the editors and physicians were: socialized medicine, the New Jersey Health Plan, the new Salem County Memorial Hospital, the use of it by the DuPont Chambers Works at Carney's Point, the possibility of new clinics and a resident physician, the new Elmer Community Hospital, and Sunday coverage.

The meeting adjourned in an air of friendliness and cooperation between the press and the medicos.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

The Muhlenberg Hospital in Plainfield was host to the *Union County Medical Society* at its annual business meeting on April 12. DR. FREDERIC W. LATHROP, the retiring president, called the meeting to order at 9 p. m.

The following officers for 1950-51 were unanimously elected: President, DR. HERSCHEL S. MURPHY; First Vice-President, DR. LOUIS WEGRYN; Second Vice-President, DR. NORMAN W. BURRITT; Secretary, DR. EDWARD G. BOURNS; Treasurer, DR. HENRI ABEL; Reporter, DR. EMANUEL M. SATULSKY.

DR. STANTON H. DAVIS and DR. WATSON B. MORRIS were elected as members of the Board of Trustees.

The following were elected to full membership: DR. ANTHONY BEBBINO of Berkeley Heights; DR. JOHN C. BENTLEY of Elizabeth; DR. GEORGE F. LANE of Plainfield, DRS. ALDEAN S. INGRAM and JAMES W. ROBINSON of Westfield were accepted as transfers from the Westchester, N. Y., Medical Society.

It was announced that this society has enrolled as a group in the Blue Cross Hospitalization Plan.

Dr. Lathrop gave an inspiring address before administering the oath to the newly elected officers and turning the meeting over to the new president, Dr. Herschel S. Murphy. Dr. Murphy immediately announced his committees for the coming year and proposed several changes to increase interest and attendance in the meetings.

SOCIETY OF SURGEONS

W. H. McCallion, M.D., Secretary

On May 17, the Society of Surgeons of New Jersey, had its annual spring meeting. The morning session was devoted to six papers: one each on empyema, fracture of the ankle, unusual urologic anomalies, ileus from gallstones, full term abdominal pregnancy, and gastro-jejunal ulcers treated by vagus section. In the afternoon there was a showing of scientific films covering resection of the stomach, vagotomy, lobectomy, ileostomy, colectomy, and transplantation of the ureters. In the evening there was a banquet at the Montclair Golf Club at which Mr. Chester Williams (chief of the information service of the U. S. Mission to the United Nations) was the principal speaker. He entitled his talk "The World Wobbles on Its Axis". Among the participants in the program were Doctors Nicola, Sabety, Bortone, Weigel, Campbell, Klostermyer, Tomec, Waters, Hobart and Schaaf.

WOMAN'S AUXILIARY

GOVERNOR SPEAKS AT HEALTH CONFERENCE

The Fourth Annual Spring Conference of the Woman's Auxiliary to The Medical Society of New Jersey on "School Health Services in New Jersey" held at the Medical Society Headquarters on June 5, 1950, included four panel discussions in the morning, luncheon on the lawn and a general afternoon session featuring a talk by Governor Driscoll.

The conference was held in conjunction with the New Jersey State Council for the Improvement of School Health Services. It was opened by a short meeting presided over by Mrs. Asher Yaguda. Dr. Samuel Blaugrund gave a resumé of the four point school health program from its birth at the 1945 New Jersey Pediatric Society meeting to its present organization on a state level. The four points are:

1. Strip to the waist examination.
2. Examinations on admission and in the fourth, eighth and twelfth grades.
3. Organized mental hygiene program in each school and
4. Yearly x-ray examinations of all school teachers and adult school personnel.

Dr. Wilson Guthrie then read a message from Mr. John H. Bossart, Commissioner, New Jersey State Department of Education, stressing the need for a cumulative health record for every school child including an eye examination with both near and far-vision tests.

Dr. Daniel Bergsma, Commissioner of our State Department of Health pointed out that "Health is indivisible", i.e., mental and physical health cannot be separated. Neither can the state differentiate between the health of its various age groups. However, because of the higher morbidity, more attention is usually paid to the health of the very young and the very old.

The four panels were held simultaneously from 10:45 a. m. until noon, and their conclusions reported at the afternoon meeting, Mrs. Paul E. Rauschenbach, presiding. Dr. Aldrich C. Crowe, president of The Medical Society of New Jersey, greeted the audience and applauded the results obtained by the voluntary cooperation of the participating agencies in the improvement of school health; and particularly the work of the Woman's Auxiliary. Dr. Grace M. Kahrs, president of the New Jersey State Council for the Improvement of School Health Services, also praised the work and emphasized the need for the organization of councils in counties where none exist and urged that this group concern itself with carrying out recommendations of the morning panel sessions.

Mrs. R. John Cottone, president of the Woman's Auxiliary extended a warm welcome to the group. She spoke of the interest in the school health program shown by doctors, nurses and teachers, and stressed the necessity for arousing that interest in the public.

The reports of the morning panel sessions were most interesting. Panel I "What Constitutes an Adequate School Health Examination?" with Dr. William V. Carroll as moderator was reported by Dr. George A. Wheatley, Third Vice-President of the Metropolitan Life Insurance Company. This group felt that the school examination should ascertain the health needs of the child, using all the means possible to interpret these needs to the family and to the school so that the needs will be met. Both children and parents should be prepared for the examination. Parents should attend if possible, ten to fifteen minutes should be allowed for each child. A follow-up conference was suggested for children who needed attention.

Mr. Mason A. Stratton, Atlantic County Superintendent of Schools was both moderator and reporter for Panel II on "Who is Concerned with the School Health Program and what Minimum Facilities Should be Provided for the School Health Examination?" It was felt that a survey should be made by The Medical Society as to an adequate fee for the school physician and that the resulting recommendations should be sent to the Board of Education. More education of the students and parents is needed as to the meaning of the four point program, and in following the recommendations to remedy physical and mental defects. Meetings should be arranged with school teachers, physicians and parents to discuss common health problems.

Panel III under the direction of Miss Lula P. Dilworth on "How Shall We Meet Mental Health Needs in the School?" was reported by Dr. Geoffrey W. Esty, Director of the Bureau of Constructive Health, New Jersey Department of Health. This panel made these

recommendations in order to get the school mental health problem before the citizens of New Jersey:

1. That the Woman's Auxiliary establish a committee to foster the development of a specific mental health program for children of all ages.
2. That the New Jersey Mental Hygiene Society and the New Jersey Welfare Council be invited to become participating members in the New Jersey State Council for the Improvement of School Health Services.
3. That we improve the selection procedures of teachers and students and
4. That we improve the mental health indoctrination of doctors, nurses and child study teachers.

Panel IV "How Shall We Meet the Needs of the Physically-Handicapped Child?" under the guidance of John J. Jennings, Jr., Rehabilitation Director, New Jersey Tuberculosis League was reported by Dr. Jerome Kaufman, President of the New Jersey Heart Association. This Panel recommended:

1. That all handicapped children be assigned to regular school classes whenever possible; otherwise to special groups and lastly for individual instruction.
2. Appropriation from both public and voluntary sources of money to obtain proper personnel for handicapped children.
3. Wide distribution to doctors, teachers, social workers, etc., of the *Directory of Health Services* prepared by the Conference for Handicapped Children.
4. Consideration should be given to revising the present law to lower the age of instruction of handicapped children to 3 years and 5. Parents, children, employers and general public need to be educated to accept the handicapped person. Education and treatment of the handicapped child is an investment by the community, not an expense.

Governor Driscoll spoke to the group on the necessity and economy for the state to solve its own health problems rather than sending them to Washington. He stressed the need for additional funds for these increased facilities. If the taxpayer is educated to the value of the school health program he will be prepared to pay for it. The Governor's talk concluded the interesting all-day session.

Mrs. George W. Irmisch,
Chairman of Publicity.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Winn, Press and Publicity

The *Woman's Auxiliary to the Medical Society of Atlantic County* had a dual pleasure on May 10, at the Traymore Hotel. A delightful luncheon was served in honor of the retiring president, Mrs. Louis Rosenberg. Mrs. Harry Subin and Mrs. Allen Reick were in charge of arrangements for this fete. The second highlight of the afternoon was the installation of a new president for 1950-51, Mrs. Clarence Whims. The installation of the new officers was made by Mrs. David B. Allman who is now serving in the capacity of President to the Woman's Auxiliary to the American Medical Association. This was indeed a rare pleasure and it is the first time it has ever been afforded any president of this Auxiliary.

Mrs. Rosenberg spoke briefly about her passing year as one of much pleasure and explained proudly the concrete cooperation of her entire staff.

Mrs. Whims' acceptance was in the nature of sincere promise to further all the laws and principles of the organization.

Bergen County

Mrs. Winton Johnson,
Chairman, Press and Publicity

The regular meeting of the *Woman's Auxiliary of the Bergen County Medical Society* was held on May 9, at Bergen Pines Hospital in Paramus. Mrs. Wilma Marrgraff, Assemblywoman from Bergen County, addressed the membership in a most informative talk on legislation as it affects public health and medicine.

Mrs. Marrgraff encouraged the Auxiliary members to promote the plans for a state medical college. New Jersey has no medical school of its own, and it is acknowledged generally that one is needed. The citizens of New Jersey must work to get something like this for their young people—and they must bring forward their ideas about the location, administration, and the sources of revenue for it.

Camden County

Mrs. Walter A. Crist,
Chairman, Press and Publicity

The annual spring luncheon of the *Woman's Auxiliary to the Camden County Medical Society* was held on May 2, at Log Cabin Lodge, Medford Lakes.

The program included selections by the Woodbury String Trio.

Installation of officers for the coming year took place. Mrs. Thomas H. McGlade, of West Collingswood, succeeded Mrs. Harold K. Eynon as President; Mrs. H. F. Wescott, President-Elect; Mrs. William Braun, First Vice-President; Mrs. Kenneth L. Athey, Second Vice-President; Mrs. William Browning, II, Third Vice-President; Mrs. Martin Swieckl, Recording Secretary; Mrs. Penrose Thompson, Corresponding Secretary and Mrs. Benjamin Lee, Treasurer.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

A report on its studies to June 1 was submitted to Governor Driscoll by the Committee on Local Health Administration which he appointed in February.

Mrs. Gloanna Wallace MacCarthy, former Assemblywoman, Newark, is chairman of the Committee. Other members include Dr. Samuel Blaugrund, chairman of the Welfare Committee of The Medical Society of New Jersey, and Dr. Roscoe P. Kandle, Trenton, Field Director of the American Public Health Association. A full membership list of the Committee appeared in the June issue of The Journal of The Medical Society of New Jersey.

Since this was only an interim report, the Committee made no specific recommendations at this time. The report served, however, as information and as a basis of orientation for groups and individuals who presented their views at the public hearing held by the Committee at the State House, Trenton, on June 29.

The report summarized existing New Jersey health laws, the present status of local health services, trends toward larger local health units in New Jersey, discussion of Committee meetings, basic principles and concepts on which the Committee was agreed, and proposed next steps.

In its statement of basic principles and concepts, the Committee said:

"New Jersey has significant reason to take prompt action to strengthen its public health services, particularly those provided through local government. To secure the full and rich benefits which public health and preventive medicine of the next decades can bring to all our citizens, and minimize the mounting costs of illness, it is imperative that the public health services be provided through a practical, modern administrative structure, by a technically competent staff.

"Sound administration would seem to require the utilization of existing, available state funds under a grant-in-aid principle tied to the minimum standards of performance.

"With respect to local health administration itself certain principles are applicable. These basic concepts, stated in terms of general principles, are inevitably broad and are a necessary prelude to any crystallization of the Committee's judgment on the content of any legislation which it may recommend to the Governor, the Legislature, and to the public. Effort has been made to reconcile the best experience and thinking in administration with our citizen's tax requirements and with traditional values of democratic self-government. The problems of administrative and taxable capacity must be solved within a democratic framework.

"1. There must be fewer, much larger, more effective and better local health departments.

"2. Larger health jurisdiction boundaries must be subject to the approval of the State Department of Health.

"3. The health unit must have authority to pass health ordinances covering the entire jurisdiction, with responsibility for enforcement of State Public Health law, State Sanitary Code, and its own ordinances.

"4. The unit must have authority to employ necessary staff, licensed and qualified as required by law. . . Every effort should be made to protect present qualified local health personnel on a career basis.

"5. The health unit must have authority to receive funds to carry out its purposes; from municipalities within its jurisdiction; from Board of Chosen Freeholders; from State Department of Health; and from other sources, with proper safeguards.

"6 There must be an integration of the official services of local boards of health, or of the local health boards of municipalities in a county or in part of a county; or integration on a multi-municipal health jurisdiction basis regardless of county lines. The Committee has left the door open to several alternatives on this basic organization problem, pending further information from the public."

In listing its next steps, the report states that the Committee will soon draft a proposed bill for presentation to the 1951 Legislature.

In its discussion of existing local public health services the report states:

"Only 51 per cent of New Jersey's citizens have the benefits of the services of a full-time licensed health officer; 14 per cent have the services of a part-time health officer; and *35 per cent of New Jersey's citizens do not have the services of a licensed health officer at all.* Seventy-two per cent of our New Jersey municipalities have no licensed health officer. In seven counties, there is not a single full-time health officer.

"Seventy-seven municipalities employed a full-

time licensed health officer in 1948; 80 employed a licensed health officer on a part-time basis; 412 municipalities employed no licensed health officer at all.

"The availability of full-time, qualified, and licensed personnel in adequate numbers is an indication of the adequacy of local health administration.

"The levels of health and community well-being are generally higher in communities which have full-time, licensed, public health personnel in adequate numbers than in communities which do not."

The report also lists fears, misconceptions, and other reasons which the Committee believes were responsible for the failure of past efforts to improve local public health services.

BOOK REVIEWS

For the New Mother. By Mildred V. Hardcastle, R.N.; illustrated by Shirley Tattersfield. Pp. 163. Phila., John C. Winston Co., 1948. ($2.00)

This simple book treats an old subject with an insight and understanding that can be used to help the new mother form a routine and still develop a pleasurable experience. Mildred Hardcastle seems to have arrived at some practical household shortcuts that will make the novice feel more at ease and self-assured. Advice is offered in an easy style and neighborly manner which is pleasant and instructive reading.

The book deals more with the problems of the housewife in conjunction with the care of the child in its progressive development through the first year. The author starts with the most elementary problems: for example, how to fold the diaper and hold the baby. This is followed with a detailed schedule for the family. The father (who is often a neglected individual in a new family) is given a place of importance in the day's routine. Menus which are simple to prepare and nutritious are provided along with many shopping and cooking aids. She emphasizes the importance of self-care, including exercise, rest and nutrition, so that at the end of the day the mother is able to enjoy her evenings free of accumulative tension.

Separate chapters are devoted to making the formula and bathing the baby. Especially noteworthy is the chapter entitled "For Emergency Only". This includes simple remedies on how to deal with colic, croup, fever and choking. She stresses the importance of using this information in correlation with the advice of the pediatrician.

JEAN SCHACHTER, R.N.
NATHAN ZUKERBERG, M.D.

A Textbook of Physiology (originally by William H. Howell, M.D.) ed. by John F. Fulton, M.D. 16th ed. Pp. 1258. Philadelphia, W. B. Saunders Company, 1949. ($10.00)

A distinguished panel of special workers contributed their talents in maintaining standards originally established by Dr. Howell. There has been extensive revision of text, deletion of obsolete material, with rewriting of the chapters on endocrines, electro-cardiography, the gastrointestinal tract and muscle physiology as of early 1949.

This edition has been reset with a slightly longer line and page. It continues to serve the student of physiology in basic science very well.

IRVING SHAPIRO, M.D.

Mitchell-Nelson Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D. With the collaboration of 63 contributors. 5th ed. Pp. 1658. Philadelphia, W. B. Saunders Co., 1950. ($12.50)

This latest edition further intrenches its position as the outstanding single volume in pediatrics. The revision and rewriting of many of the chapters and the introduction of several new sections have increased the length of the book by 300 pages. Of the revised sections the one on congenital heart disease is excellent. It gives a precise description of the current diagnostic procedures and in the operable lesions, a description of surgical technics.

There are new sections on parenteral fluid therapy, anesthesia, inborn errors of metabolism and viral and rickettsial laboratory diagnosis. Advances in clinical interpretation, diagnostic procedures and newer modes of therapy are evident in perusing the text. Aureomycin, chloromycetin, cortisone and ACTH are mentioned in reference to specific disorders. The section on mental and emotional development has been re-edited and elaborated and the same author has written a new section on psychologic aspects of adolescence. This revision is up-to-date, comprehensive, readable and lucid. The student, the general practitioner and the pediatrician will find this a most valuable book.

LEON I. SMALL, M.D.

Early Carcinoma of the Uterine Cervix. By Hansjakob Wespi, M.D. Pp. 271. New York, Grune and Stratton, Inc., 1949. ($6.50)

The current campaign for the early diagnosis of cancer makes this book timely and significant. The author emphasizes colposcopy as an aid in the early diagnosis of malignant lesions of the cervix and its canal, before the onset of clinical symptoms. Colposcopy was introduced 25 years ago as part of a prophylactic routine cancer detection program.

Wespi describes the very early changes in the epithelium of the cervix noted by visual inspection aided by good lighting and an optical instrument to provide magnification up to 12 times. Magnified visualization of the cervix is far superior to the naked eye inspection of the cervix which is universally accepted as indispensable in the routine gynecologic examination. The minor variations between the normal and the pathologic lesions found in the cervix are described in detail.

The comparative value of the vaginal smear and

colposcopy is discussed as well as some theoretical considerations of the origin of the cancer cells. The important problem of pre-cancerous lesions and carcinoma *in situ,* receive detailed discussion. The author believes that there is a pre-cancerous stage and cites several case histories as proof.

There is real merit in this small book, because it records the detailed study of 5000 colposcopies performed together with the use of the iodine test of Schiller. It is useful for those who use colposcopy as an additional modality in the routine diagnostic evaluation of the cervix. It is regrettable that colored photographs of the cervical epithelium as noted in the normal and pathologic states have not been included. However, histologic sections of cervical scrapings are shown in black and white.

Wespi shows the importance of colposcopy with the iodine test as a means of detecting minimal cervical lesions which can be accurately biopsied for histological diagnosis. However, it must be stated that colposcopy does not compete with the vaginal cytologic smear of Papanicolaou for the early detection of uterine malignancy. The smear is superior to colposcopy in this connection, but the combined use of both procedures should yield the best results in the early diagnosis of uterine cancer.

ROBERT BERMAN, M.D.

The Physiology of Thought. Harold Bailey, M.D. Pp. 313. No index. William Frederick Press, New York, 1950. ($3.75)

The aura of the nineteenth century clings to this book, written by a distinguished ophthalmologist. It is significant that the only psychology book in his bibliography is the one written by William James at the turn of the century. Dr. Bailey's ideas seem strangely naive to the contemporary psychiatrist or psychologist. Thus, he tells us in this book that neurones secrete thought, that dreams have no dynamic meaning (being merely residual reminiscences), that "thought activity in dreams creates waste products", that "if a child inherits memories pertaining to arithmetic, it will, as its brain develops, utilize these memories and the learning of arithmetic will thus be easier." That people can inherit such things as a fear of storms or a fear of snakes, and that excessive thinking causes neurasthenia!

The author's approach is curiously static. His concept of the subconscious is strictly midVictorian, and ignores all progress that has been made in psychology since the 1880s. Love relationships are dismissed as "of little value". Dr. Bailey believes that given the same physical care, an orphan child will thrive as well as one with affectionate parents. The author's concept of child guidance is tokened by such sentences as: "The school system is conducive to nervousness in that frail children are tempted to overtax their weak thought cells."

Fortunately the book has no index, so that the casual reader will not get into difficulties by finding easily the citations to the appropriate pages.

WILLIAM S. SCHRAM, M.D.

Clinical Pathology; Application and Interpretation. By Benjamin B. Wells, M.D., Ph.D. Pp. 397. Philadelphia, W. B. Saunders Company, 1950. ($6.00)

The arrangement of the material in this book is exactly as the physician uses it. Beginning with a clinical situation, the applicable laboratory procedures are selected and their contribution to the problem are discussed. Special chapters cover: infectious diseases including viral, rickettsial and mycotic infections; diseases of the gastrointestinal system; the respiratory system; diseases of the kidney and urinary tract; diseases of the blood; diseases of the cardiovascular system; metabolic and endocrine disorders; clinical laboratory studies in surgery and in obstetrics.

In the introductory note, the author states that the practitioner must know at least three things about every laboratory procedure: (1) when to use it; (2) how to interpret the results; and (3) its technical or physiologic limitations. He emphasizes the fact that laboratory results are only one aspect of the total clinical observation and that their interpretation is valid only as they pertain to all other manifestations which characterize the normal and abnormal state of the patient.

This volume will serve as an excellent aid to the clinician in following the progress of the patient. It is concise and arranged in such a manner as to make the laboratory procedures for any given case readily available. The illustrations are excellent and ample.

SAMUEL A. GOLDBERG, M.D.

The Envelope. By James S. Plant, M.D., Commonweath Fund, New York, 1950. Pp. 299. ($3.00)

Although Dr. Plant died here in 1947, his book, *The Envelope* was not released until April 1950. The "envelope" is conceived of a sort of "psychoosmotic" membrane between a child and the social pressures that rain upon him. The book is a study of the impact of the world upon the child. While most pediatricians think in terms of vitamins and immunities, and most psychiatrists are concerned about father-mother relationships, Dr. Plant was always most interested in what effect social forces had upon the developing personality. This book is a report of his observations during his long period of service with our Essex County (N. J.) Juvenile Clinic. He analyzes the effect on the child of such forces as urbanization, the church, membership in a minority group, suburban life, vocational or school failure, et cetera. He offers no pat prescriptions but he does open some fascinating vistas. The book is written in the easy, informal, thought-provoking style which those associated with Dr. Plant had learned to know and love. *The Envelope* is a text which will stimulate the pediatrician, parent or psychiatrist to do his own thinking about child guidance. Since it gives the questions without the answers it is, perhaps, the highest form of pedagogy.

RALPH N. SHAPIRO, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **July, 1950** **No. 7**

THE practicing physician and the public health worker are well aware that the magnitude of the chronic disease problem has been increasing. For this reason a practical procedure for screening out early cases of diabetes, cancer, tuberculosis, and syphilis and bringing them to the attention of the physician is very important.

THE CONCEPT OF MULTIPHASIC SCREENING

As tests for specific diseases have been perfected, methods have been developed for applying these tests on a mass basis. The chest X-ray for tuberculosis and the serological test for syphilis are examples of tests suitable for mass application. Recently quick and economical methods of testing for blood sugar have been worked out. The determination of hemoglobin levels, vision, and hearing testing done routinely as in school examinations, and the taking of blood pressures, are simple procedures in common practice.

Until recently mass testing of the population, using the tests and procedures mentioned above, has been limited. There have been separate mass surveys for tuberculosis, for syphilis, and for nutritional deficiencies. It is perfectly logical now for public health administrators to ask the question, "Why not combine as many of these tests as practical into a battery of tests, reduce the over-all cost of administering them, and thereby encourage universal usage?"

The Concept of Multiphasic Screening, A. L. Chapman, M.D., Public Health Reports, October 21, 1949.

MULTIPHASIC SCREENING EXAMINATIONS— AN EXTENSION OF THE MASS SCREENING TECHNIQUE

Public health workers are now directing their efforts to the control of the chronic diseases. Emphasis is correctly placed on prevention in chronic disease control in all fields of public health endeavor. The technique here presented is based on a fundamental concept in preventive medicine, the concept that early detection, early diagnosis, and adequate treatment can accomplish substantial reduction in disability and deaths from chronic disease.

This concept of preventive medicine is, of course, the basis for "periodic health examinations" which have been promoted during the past quarter of a century. These examinations, for the early detection of disease, are relatively expensive in terms of a physician's time and laboratory services. Viewed as a technique for chronic disease control, they have severe limitations.

A different approach to the detection of disease in its early stages has long been known to public health agencies. Mass chest X-ray surveys using photofluorographic equipment and mass serologic testing programs for the detection of syphilis are well-established methods. Recently, comparable screening techniques have been developed for early detection of diabetes, certain types of heart disease, and cancers of certain sites.

These screening procedures are capable of wide application; they are relatively inexpensive per person tested; and they require relatively little time on the part of the physicians. They have been used, for the most part, in separate case-finding programs.

A population group in one city is screened for tuberculosis. In another, a group is screened for diabetes and, in still another, for syphilis. The question then arose—When we screen a population group for tuberculosis, why not also screen for syphilis, diabetes, heart disease, and cancer at the same time? The advantages of combined screening operations through a multiphasic screening procedure then become quite obvious.

For the individual who is served and for the administrative agency, it has many advantages. The discovery of active tuberculosis and early syphilis will vary with the type of population screened. However, for the adult population of the United States, the discovery rate of each of these diseases would probably be not less than 3 per 1,000. In the case of diabetes, studies have indicated that approximately 7 previously unknown cases per 1,000 persons tested would be discovered through blood-sugar and urine-sugar screening devices. A careful follow-up of persons whose miniature chest X-ray films disclosed abnormal cardiac shadows revealed that 10 per 1,000 of the group studied had previously unknown, clinically significant heart disease.

By combining tests for these several diseases, one would expect to find, in a multiple screening of 1,000 persons, approximately 20 to 30 persons with disease requiring the attention of a physician. Other tests such as hemoglobin determination, albumin test of the urine, blood pressure, weight, vision, and audiometric testing might well be incorporated into the battery. The screening procedures in all of these tests can be carried out by technicians. A physician is required only for rapid interpretation of certain test results and thereafter, when there appears to be some lead which justifies a diagnostic study of the patient.

In San Jose, California, after extensive joint planning by a number of agencies, a multiphasic screening program was conducted on a trial basis last year. The County Medical Society, City Health Department, and State Department of Public Health carried out a survey covering 945 employees in four establishments. The screening procedures included in miniature X-ray film of the chest, test of the urine for albumin and glycosuria, a serologic test for syphilis, and the determination of blood-sugar level. A brief history form was used, with questions relating to heart disease, tuberculosis, diabetes, and syphilis.

About 15 minutes was required for each person tested. Although follow-up was deficient in certain respects, 13 cases of previously unknown significant disease were discovered and placed in the hands of physicians for care. These were cases of diabetes, active tuberculosis, and cardiovascular renal disease. Sixteen other cases of disease—previously known—were also disclosed.

Numerous problems in connection with multiphasic screening procedures have yet to be solved. These problems lie in the fields of technical development, professional education, professional relationships, and administration.

One problem is that of professional relationships. It should be emphasized that the multiphasic examination is a screening procedure, and it is to be sharply differentiated from diagnosis. Screening represents a lead to diagnosis, and it is only that. Further definitive studies are needed and should be carried out where the patient is to receive his medical care. It may be desirable to repeat certain of the tests before the individual is referred for what may be an expensive diagnostic study.

The multiphasic screening procedure is not a substitute for a visit to a physician. Annual visits to a physician, whether symptoms are present or not, are obviously desirable.

The multiphasic screening procedure, through which 20 to 30 cases of significant disease may be discovered per 1,000 persons tested, constitutes a practical approach to the present-day problems in preventive medicine. This preventive technique—designed for the early detection of groups of these diseases—merits further consideration, study, and exploration.

Multiphasic Screening Examination, Lester Breslow, M.D., American Journal of Public Health, March, 1950.

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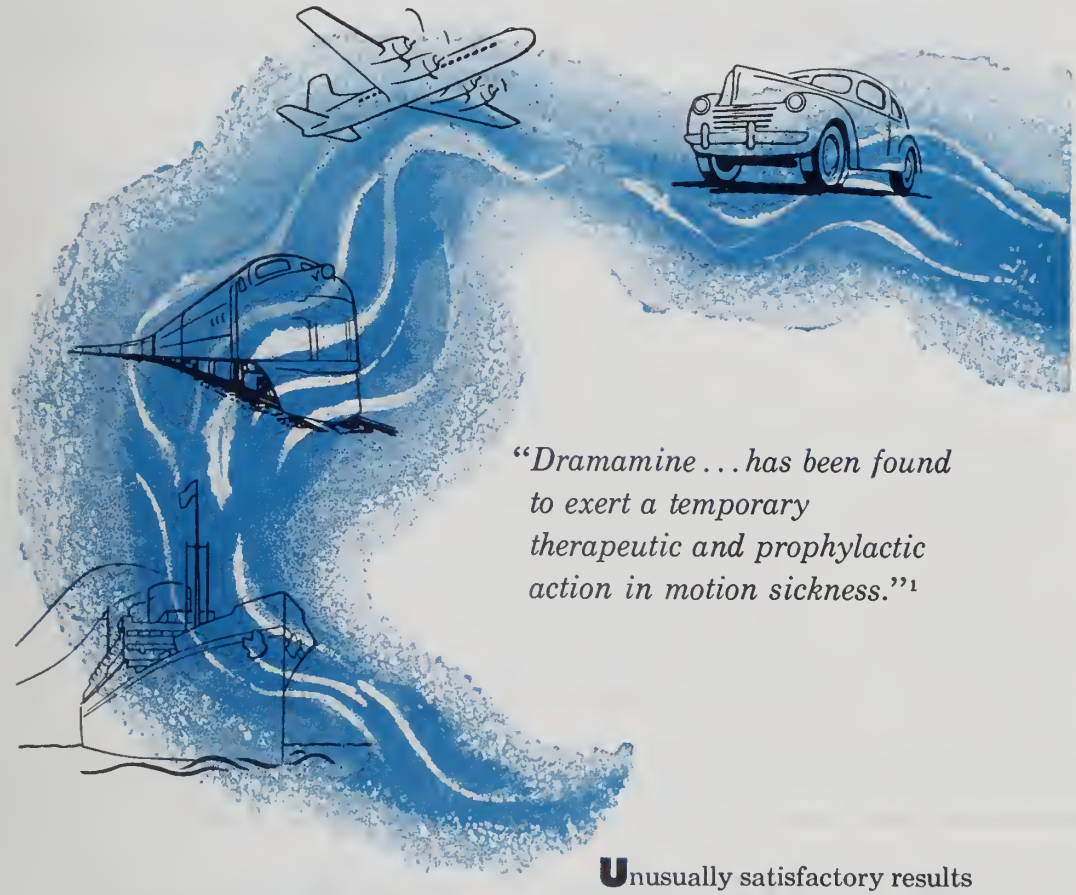

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1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

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CONTENTS—Pages 361 to 408

EDITORIALS— Page
SPEAK NOW 361
PRIVACY, PATIENTS AND PRACTITIONERS 362

ORIGINAL ARTICLES—
THE CANCER PROBLEM — Nicholas G. Demy, M.D., Plainfield, N. J. 363
OPERATION FOR NON-SPECIFIC RHINITIS—Herman C. Comora, M.D., West New York N. J. 369
IMMEDIATE TREATMENT OF BARBITURATE POISONING—Theodore R. Robie, M.D., East Orange, N. J. 370
PREGNANCY COMPLICATED BY SUBARACHNOID HEMORRHAGE—David B. Gershenfeld, M.D., and Lewis E. Savel, M.D., Newark, N. J. 374
VERTIGO—Hans Brunner, M.D., Newark, N. J. 375
OCCUPATIONAL DERMATOSES—Seymour L. Hanfling, M.D., East Orange, N. J. 379
CARBON MONOXIDE DETECTION IN BLOOD EXAMINATIONS—H. C. Goldberg, M.D., Plainfield, N. J. 382
MANAGEMENT OF HYPERTHYROIDISM — V. Earl Johnson, M.D., Atlantic City, N. J. 383
LEFT HEPATO-JEJUNOSTOMY FOR BILIARY OBSTRUCTION — Robert L. Lewis, Jr., M.D., Elizabeth, N. J. 387

ORIGINAL ARTICLES— Page
ROLE OF THE GASTROSCOPIST IN DIAGNOSIS — Jacob A. Riese, M.D., West New York, N. J. 388
SPONTANEOUS RUPTURE OF THE HEART—Charles K. Rath, M.D., Elizabeth, N. J., and H. Preston Price, M.D., Ridgewood, N. J. 390
MURINE TYPHUS IN NEW JERSEY—William W. Weissberg, M.D., and Adolph J. Herz, M.D., Elizabeth, N. J. 393
WHY NOT X-RAY BEFORE MARRIAGE?—Charles V. Craster, M.D., D.P.H., Newark, N. J. 395

STATE ACTIVITIES—
County Society Meeting Dates 396
Course in Advanced Medicine and Surgery 396
Supplementary List of Members No. 5 397

OBITUARIES 397
PUBLIC HEALTH NEWS 398
COUNTY SOCIETY REPORTS 399
WOMAN'S AUXILIARY 402
BOOK REVIEWS 405
TUBERCULOSIS ABSTRACTS 407

Roster of Officers, Advertising Page 3 A

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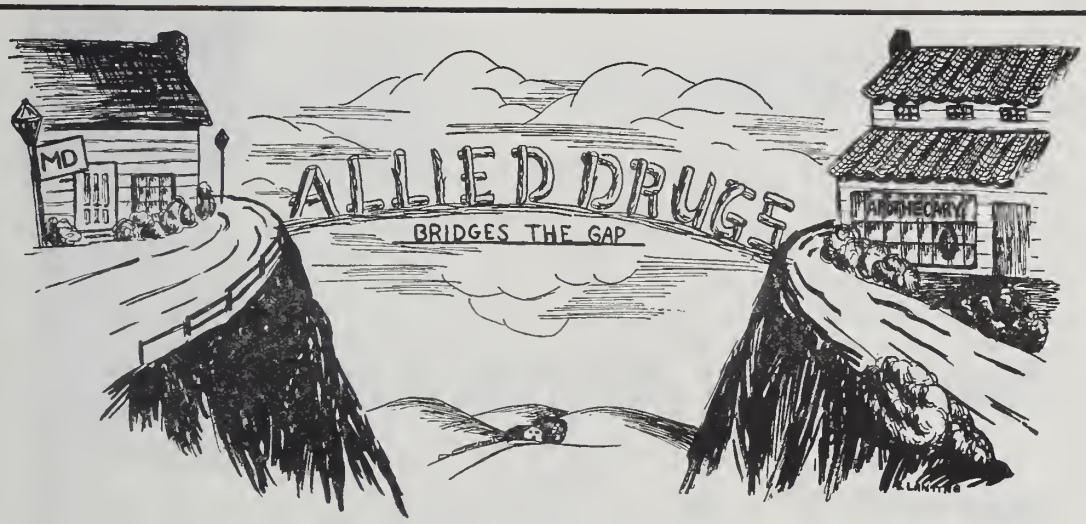

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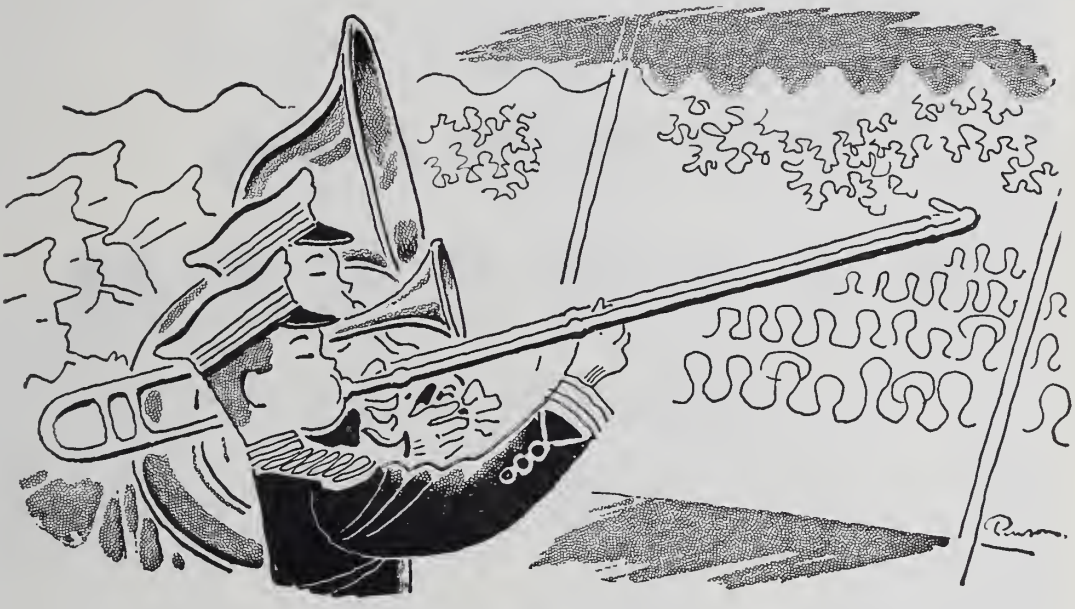

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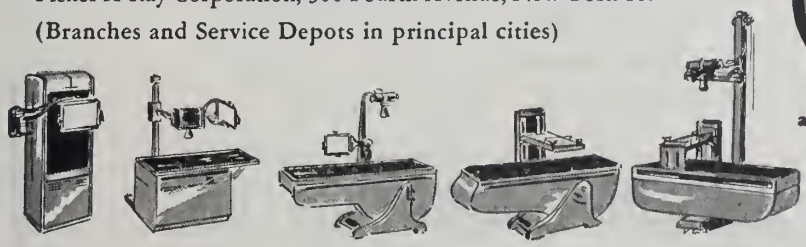
"What's best for me in x-ray? What kind, how much?" The right answer to this question is important... you'll have to live with it... work with it... depend on it. You'd like to keep your x-ray outlay at a minimum: still want to be sure that the equipment you buy can do all the things you'll need to do, now and later.

In short, you're at the point where it would be prudent to call for experienced counsel . . . and your local Picker representative is the man who can offer it to you. He's analyzed and solved dozens of problems like yours. He's primed to *serve* you, not pressured to *sell* you. In your own best interest call in your local Picker man before you come to *any* decision on *any* x-ray apparatus: then judge for yourself. Picker X-Ray Corporation, 300 Fourth Avenue, New York 10. (Branches and Service Depots in principal cities)

Picker x-ray

all you expect . . . and more



Fluoroscope — the "Meteor" — the "Century" — the "1225" — the "Constellation"

these are some of the x-ray units in the wide Picker line

PICKER IN NEW JERSEY IS AT 972 BROAD STREET, NEWARK 2, *(Mitchell 2-0482)*

Walker-Gordon

NUTRITIONAL CONTROL CERTIFIED

DOCTORS ARE SHOWING
INCREASED INTEREST* IN

WALKER-GORDON

CERTIFIED

LOW FAT (Skimmed) MILK

Walker-Gordon Certified Skimmed Milk is simply Walker-Gordon Certified Whole Milk from which the cream has been removed. It contains all the nutrients in Certified Whole Milk except the butterfat and fat soluble vitamins. It contains all the minerals including calcium and phosphorus, all the water soluble vitamins, all the amino acids, practically all the proteins, and about one-half the calories found in whole milk. It is unsurpassed as a source of high quality protein which is so important during pregnancy, lactation, period of rapid growth and old age.

*AN ACTUAL SURVEY of 8,500 physicians in the New York City area has shown that Walker-Gordon Certified Skimmed Milk is widely used by the Medical Profession. The following uses were mentioned in the survey: Pregnancy and Lactation, Obesity in Children and Adults, Abnormal Bile Secretion, Celiac Disease, Infant Feeding Cases, Gastric Ulcers, Diarrhea, Psoriasis, Allergy, Diabetic Diets, Colitis, Acne, Eczema, and Hypertension.

Walker-Gordon Certified Skimmed Milk is handled by many leading dairy distributors in New York, New Jersey and Pennsylvania. Write or phone

WALKER-GORDON LABORATORY CO.

PLAINSBORO, N. J. **Tel. Plainsboro 2750**

release the FLOOD GATES

in Cardiac Edema Control

". . . the diuretic drugs not only promote fluid loss but in many instances also effectively relieve dyspnea . . . not only may the load on the heart be decreased but there may also occur an increase in the organ's ability to carry its load . . . With good average response the patient perhaps voids about 2000 cc. of urine daily, but in exceptional instances the amount rises to as high as 8000 cc."[1]

"Not only are the diuretics of immense value in cases of left ventricular failure . . . but where edema is marked, as it is most likely to be in failures occurring in individuals with chronic nonvalvular disease with or without hypertension and arrhythmia, their employment is often productive of an excellent response. In [edematous patients with] active rheumatic carditis (rheumatic fever) the use of these drugs may be life-saving."[2]

Salyrgan-Theophylline is effective by muscle, vein or mouth.

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THEOPHYLLINE

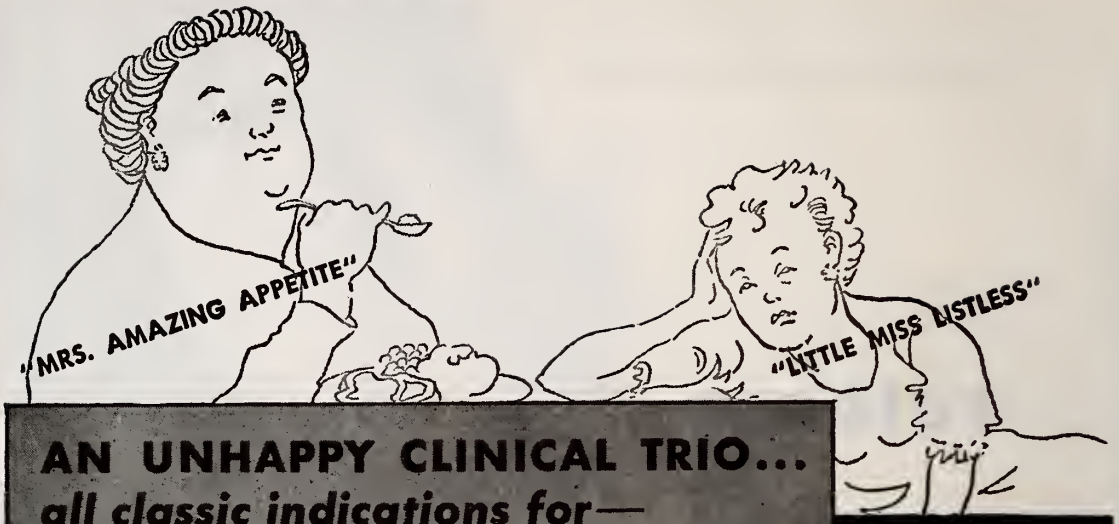
BRAND OF MERSALYL AND THEOPHYLLINE
TIME TESTED • WELL TOLERATED

AMPULS (1cc. and 2cc.) • AMPINS (1cc.) • TABLETS

Winthrop-Stearns INC.
NEW YORK, N. Y. WINDSOR, ONT.

1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.
2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744.

Salyrgan, trademark reg. U. S. & Canada—Ampins, reg. trademark of Strong Cobb & Co., Inc.



AN UNHAPPY CLINICAL TRIO...
all classic indications for—

DEXOVAL

TRADEMARK

HYDROCHLORIDE

(BRAND OF METHAMPHETAMINE HYDROCHLORIDE)

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

...a potent central stimulant which:

- brightens the depressed "Miss Listless" by imparting a feeling of increased vitality
- dulls the excessive hunger drive of "Mrs. Amazing Appetite"
- tends to lift the gloom of "Mr. Depressed Alcoholic", facilitating rehabilitation

DEXOVAL* HYDROCHLORIDE provides:

- *few unwanted side-reactions*
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- *prolonged benefit*

AVAILABLE: Bottles of 100 and 1,000 tablets, 2.5 and 5 mg.

THE VALE CHEMICAL CO., INC.
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*Trademark of The Vale Chemical Co., Inc.

AUREOMYCIN

CRYSTALLINE

in Infections of the Puerperium

During the past year, obstetricians have become increasingly impressed with the ability of aureomycin to prevent or arrest infections of the puerperium. Where infection is feared, or has appeared, this broadly effective antibiotic is highly useful. Drug fastness and allergy are very rare following aureomycin. It is believed that this new crystalline form of aureomycin obviates nearly all side reactions.

Aureomycin

Aureomycin has also been found effective for the control of the following infections:

Acute amebiasis, bacterial infections associated with virus influenza, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, brucellosis, chancroid, Friedländer infections (Klebsiella pneumonia), gonorrhea (resistant), Gram-negative infections (including those caused by some of the coli-aerogenes group), Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, peritonitis, pertussis infections (acute and subacute), primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, sinusitis, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia, typhus and the common infections of the uterus and adnexa.

Capsules:
Bottles of 25, 50 mg. each capsule.
Bottles of 16, 250 mg. each capsule.

Ophthalmic:
Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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● One important reason why Abbotts Ice Cream and Jane Logan Deluxe Ice Cream are better tasting and consistently pure lies in the history of the cream used.

Every drop of cream used in Abbotts and Jane Logan Deluxe is produced in Abbotts own country creameries. Therefore, it is quality-controlled right from the farm to the ice cream dealer. Abbotts own system of laboratory checks provides a case history of the cream's purity all the way.

Because of this known history of cream-quality, doctors safely recommend Abbotts and Jane Logan Deluxe to their patients.

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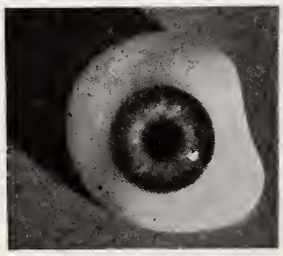
Specialists in ALL TYPES of Plastic and Glass Artificial Human Eyes Exclusively

MADE TO ORDER IN OUR OWN LABORATORY



REFERRED CASES CAREFULLY ATTENDED

EYES ALSO FITTED FROM STOCK

Plastic or Glass Selections Sent on Memorandum upon Request

Implants and Plastic Conformers in Stock

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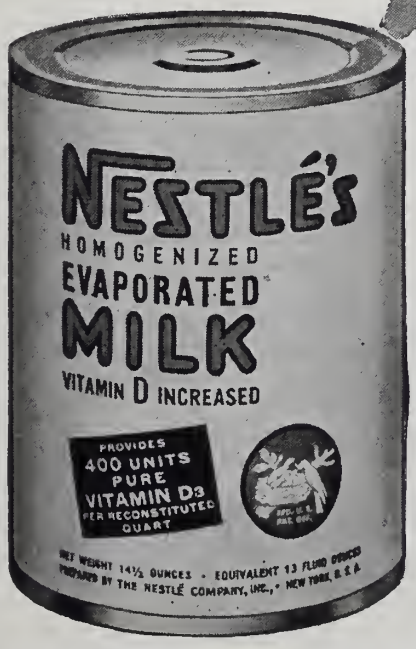
CONSTANT INSPECTION for BABY'S PROTECTION

Our inspectors examine every single ten-gallon can of fresh milk as it comes from the dairy, but this is only the beginning of the tests we apply to Nestlé's Evaporated Milk.



From herd inspection to examination of the filled cans, careful controls at every step of production assure you that Nestlé's milk is of good quality, uniform in composition, safe for even the tiniest baby.

Antirachitic protection is assured by the addition of 400 U.S.P. units of genuine vitamin D_3 to each pint of Nestlé's milk—the first evaporated milk so fortified.

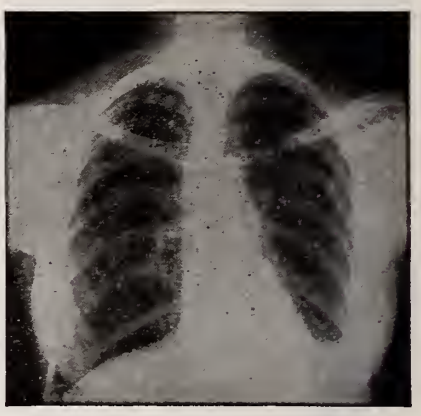
ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

APPROVED FOR VITAMIN D UPON PERIODIC TESTS

DOCTORS EVERYWHERE KNOW NESTLÉ'S

Before Treatment (*9 days prior to Dihydrostreptomycin therapy*) *Diffuse lobular tuberculous pneumonia, lower half of left lung; thin-walled cavity above hilus (3 x 3.5 cm.).*

After 3 Mos. Treatment (*2 days after discontinuance of Dihydrostreptomycin*) *Considerable clearing of acute exudative process in the diseased lung; cavity smaller and wall thinner.*



Preferred Adjuvants in the treatment of

TUBERCULOSIS

Dihydrostreptomycin and Streptomycin are unquestionably the most potent antibiotics now available for use against tuberculosis. Extensive clinical results have defined the important role of these antibiotics in suppressing the activity of the tubercle bacillus.

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

Streptomycin Calcium Chloride Complex Merck

Crystalline Dihydrostreptomycin Sulfate Merck

With this in hand

The Cardiologist is assured of

Dependability in Digitalis Administration

Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

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DAVIES, ROSE & COMPANY, Limited

Manufacturing Chemists, Boston 18, Massachusetts

D14

sleep... *measured by the patient's need*

Palatable Elixir Alurate, with its flexible, easily adjusted dosage, enables you to induce sleep in nervous, tense patients according to their individual needs. In therapeutic doses, it does not alter heart rate, respiration or other vital functions. In most cases, sleep of normal duration and depth is obtained. Easily administered, pleasant-tasting, freely miscible with liquids, each teaspoonful of Elixir Alurate contains ½ gr of allyl-isopropyl barbituric acid. Bottles of 6 oz, 1 pt, and 1 gal.

HOFFMANN-LA ROCHE INC. • NUTLEY 10 • N. J.

Elixir Alurate®

'Roche'

	Calories	Protein Gm.	Calcium Gm.	Copper mg.	Iron mg.	Phosphorus Gm.	Vitamin A I. U.	Thiamine mg.	Riboflavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
National Research Council Allowances, Sedentary Man (154 lbs.)	2,400	70	1.0	1.2	12	1.5	5,000	1.2	1.8	12	75	Small Amount
Ovaltine in Milk, 3 Servings *	676	32	1.12	0.5	12	0.94	3,000	1.16	2.0	6.8	30	417
Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk	28%	46%	112%	42%	100%	63%	60%	97%	111%	57%	40%	Abundance

* Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk.

Supplementation

A sure step to dietary adequacy

The aim of the dietary at all times and under all conditions is to provide ample amounts—not just minimum amounts—of all nutrient essentials. Only when the daily nutrient intake is fully adequate, based on the most authoritative nutritional criteria, can the possibility of adequate nutrition be assured. It is for this reason that a food supplement assumes great importance in daily practice. It should be rich in those nutrients most likely deficient in prevailing diets or in restricted diets during illness and convalescence.

The *multiple nutrient dietary food supplement*, Ovaltine in milk, is especially suited for transforming even poor diets to full nutritional adequacy. This is clearly shown by the data in the table above.

Note in particular the high percentages of the dietary allowances for nutrients and the relatively low percentage of the total calories furnished by the servings of Ovaltine in milk. Thus, without unduly increasing the caloric intake, Ovaltine in milk greatly increases the contribution of nutrient essentials. Enticing flavor and easy digestibility are other important features of this dietary supplement.

Two kinds, Plain and Sweet Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

Ovaltine

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

We gratefully acknowledge the advice and co-operation of many PHYSICIANS in helping us to plan and supply a SUPERIOR SERVICE

Washed Separately — Dried Separately — Packed Separately

- The container we furnish for used diapers sprinkles its soiled contents with an efficient antiseptic solution whenever the container lid is opened and closed.
- All plant operations are carefully supervised. A chemical check is continuously made, and bacteria colony counts of the diapers are run.
- A modern tested diaper supply service for our customer's exclusive use.

- **SAFE**
- **INDIVIDUAL**
- **DEPENDABLE**

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PAssaic 2-9641

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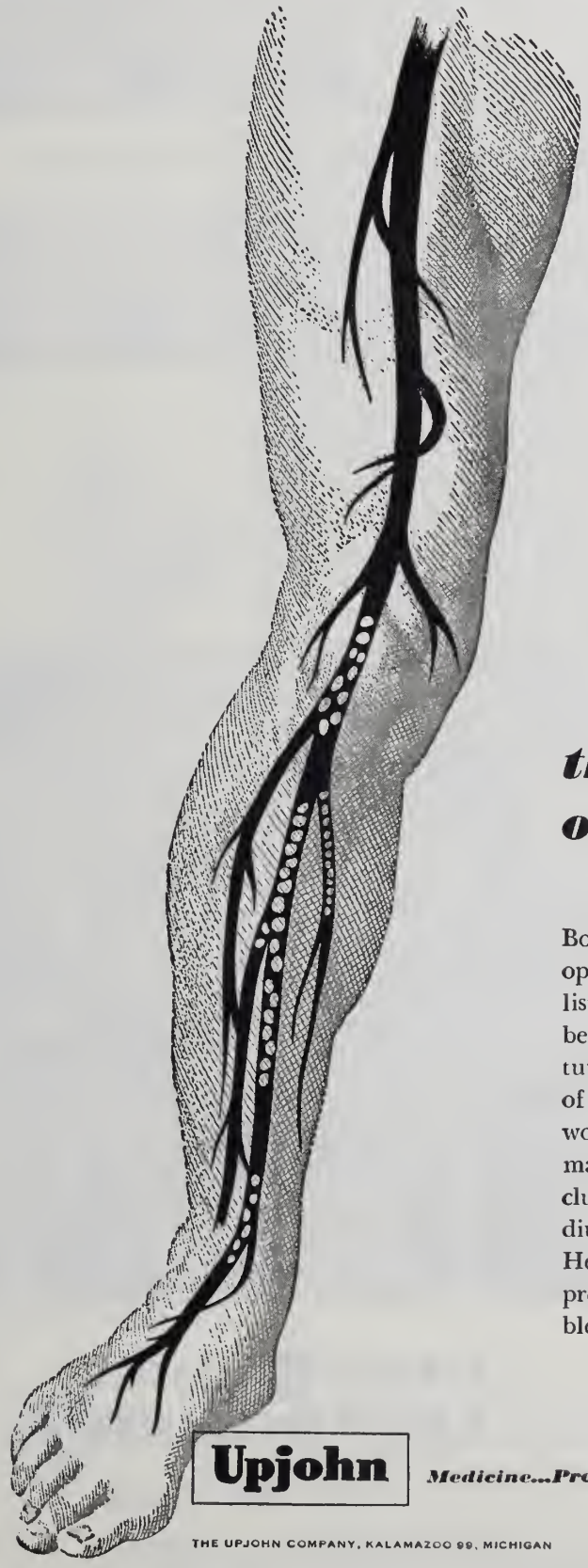


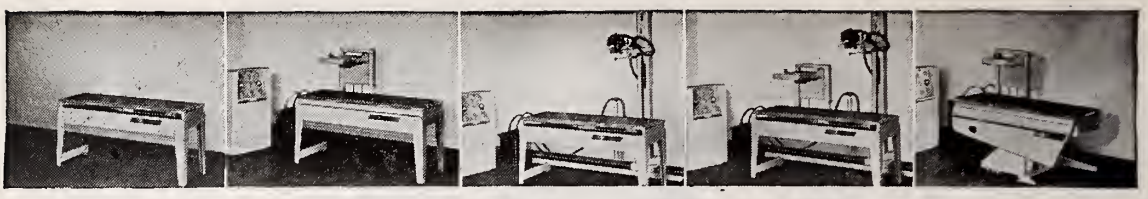
the probability of thrombi...

Both morbidity and mortality from post-operative venous thrombosis and embolism, frequent sequelae to surgery, have been dramatically reduced by early institution of anticoagulant therapy. Studies of anticoagulants by Upjohn research workers have led to the development of many Heparin Sodium preparations, including long-acting Depo*-Heparin Sodium, with or without vasoconstrictors. Heparin Sodium preparations provide promptly effective and readily controllable anticoagulant therapy.

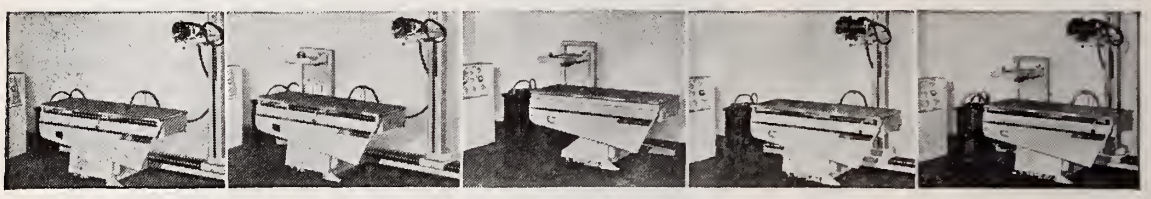
*Trademark, Reg. U. S. Pat. Off.

Upjohn ***Medicine...Produced with care...Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN



A complete range of x-ray apparatus in 10 easy steps!



THE GE MAXICON meets the medical profession's long-felt need for x-ray equipment developed to grow with an expanding practice . . . providing just the x-ray facility required . . . unit by unit as needed!

MORE than just a new x-ray unit, the Maxicon is a fundamentally new idea for a comprehensive line of x-ray apparatus. Specifically designed to grow with your practice Yes, the Maxicon permits you to choose only the x-ray facilities you actually want or require — from the simplest to the most complete unit. Comprised of a number of components that can be assembled in various combinations, it covers the range of diagnostic x-ray apparatus from the horizontal x-ray table to the 200-milliampere, two-tube, motor-driven combination unit.

The Maxicon series has a wealth of utility wherever diagnostic x-ray is employed. The practicing physician may select the basic unit, then let x-ray grow with his practice — by simply adding successive components from time to time. The medical specialist may arrange to have only the x-ray facilities his specialty requires.

The clinic or hospital will appreciate the application of a simple unit as auxiliary equipment in a busy department, or a complete radiographic and fluoroscopic combination to adequately meet the demands of any type of examination. Ask your GE representative for unique booklet demonstration.

GENERAL ELECTRIC X-RAY CORPORATION

Newark - - - - - - - 10 North Third Street

Philadelphia - - - - 1624 Hunting Park Avenue

"But, Doctor, what's a meal without potatoes!"

"Why I've eaten spuds all my life . . . don't take them away from me!"

And it takes a doctor with enduring patience to face such pleading every day. It's a patience soon worn thin if the physician hasn't prescribed Efroxine Hydrochloride.

Efroxine is a logical adjunct in the management of obesity. Efroxine offers a number of advantages over other sympathomimetic amines:

. . . It has a more rapid and longer-lasting effect with smaller dosage

. . . It has little pressor effect in the recommended dosage range. This advantage is particularly valuable in the treatment of obesity.

. . . It increases the urge to activity with relative freedom from irritability and nervous tension.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Efroxine Hydrochloride *Tablets and Elixir*

Maltbie Brand of Methamphetamine Hydrochloride

MALTBIE Laboratories, Inc., Newark 1, New Jersey

New Non-fat Dry Milk Solids Overcome Several Causes of Important Dietary Deficiencies

Milk products supply three fourths of the calcium so commonly deficient in the diets of young and old. In addition milk products provide almost half the riboflavin, one fourth the protein plus other important elements of the American diet. It is disturbing, then, to learn that the per capita consumption of dairy foods last year was the lowest in over a quarter of a century. Americans averaged less than *one half quart* of milk per day!

One important reason is the rising cost of dairy products. Another is the general desire to reduce the caloric content of adult diets.

New, improved non-fat dry milk solids overcome these and other obstacles to better dietary habits.

1. DIETARY NEEDS— Being non-fat, this milk food is excellent for low calory diets. It provides the calcium and other important minerals, high quality protein, riboflavin, and the B vitamins found in whole milk. Certain non-fat dry milk solids now also are fortified with 400 units of vitamin D per reconstituted quart.

2. COST—Grocery stores in New Jersey now have packages of improved non-fat dry milk solids that provide the equivalent of 3 quarts of fluid milk for less than 10 cents a quart.

3. FLAVOR — Unlike previous milk powders, the new non-fat dry milk solids have the same flavor as fresh milk. In blindfold tests people say they can't tell the difference.

4. CONVENIENCE — New non-fat dry milk powder now can be reconstituted into fluid milk more easily and completely. It is packaged in separate envelopes, each of which makes a quart of milk without measuring or extra mixing equipment. This food keeps in a small space without refrigeration.

Now more delicious and convenient for drinking, new non-fat dry milk solids also can be recommended to enrich many recipes. Very easy to use, they double the milk food value and increase the flavor of soups, cereals, meat and vegetable dishes.

Growing Children
need 5 to 7 quarts of milk a week. Many foods and drinks can be milk enriched this new way.

Most Adults
don't get the 5 quarts of milk they need each week. Here is a tasty milk food without fat.

Pregnant Women and Nursing Mothers
can enrich their diets this convenient way to get the needed 7 to 11 quarts of milk weekly.

Statistics and milk recommendations from U. S. Dept. of Agriculture

SANNA DAIRIES, INC.
MADISON 3, WISCONSIN

MANUFACTURERS OF SANALAC BRAND NON-FAT DRY MILK SOLIDS

Throat Specialists report on 30-day test of Camel smokers:

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

Elaine Bassett, television stylist, is one of hundreds, coast to coast, who made the 30-Day Test of Camel Mildness under the observation of throat specialists.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors Smoke Camels

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

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a long and distinguished career in urography.

NEO-IOPAX®

(brand of sodium iodomethamate)

An 18 year history of dependable roentgenograms obtained without harm to the patient distinguishes the career of NEO-IOPAX as a diagnostic urographic agent. Since 1932, *hundreds of thousands of doses of* NEO-IOPAX have been injected with virtual freedom from serious untoward reactions. No other urographic contrast medium has equalled the safety record of NEO-IOPAX. No agent, experience with which is limited to a relatively small number of patients, can be deemed to be as safe. Because the patient's life and welfare take precedence over all other considerations in diagnostic investigation of the urinary tract, urologists and roentgenologists will continue to rely—as always—on NEO-IOPAX.

Available as a stable, crystal-clear solution of disodium N-methyl-3, 5-diiodo-chelidamate in 10, 20 and 30 cc. ampuls of 50% concentration. NEO-IOPAX 75% concentration in 10 cc. ampuls, box of 5 ampuls; 20 cc. boxes of 1, 5 and 20 ampuls.

Schering CORPORATION·BLOOMFIELD, NEW JERSEY

NEO-IOPAX

SCHERING

The NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL

(Organized 1881)

THE PIONEER POST-GRADUATE MEDICAL INSTITUTION IN AMERICA

UROLOGY

A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection.

OBSTETRICS AND GYNECOLOGY

A full time course. In Obstetrics: Lectures; prenatal clinics, witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology; anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

FOR THE GENERAL SURGEON

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver.

EYE, EAR, NOSE and THROAT

A combined full time course covering an academic year (9 months). It consists of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver): clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology, physiology; neuroanatomy; anesthesia; physical medicine; allergy, examination of patients pre-operatively and follow-up post-operatively in the wards and clinics. Also a 3 months combined course.

For Information Address MEDICAL EXECUTIVE OFFICER

345 WEST 50TH STREET NEW YORK CITY 19

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting August 21, September 25, October 23. Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting August 7, September 11, October 9. Personal Course in General Surgery, two weeks, starting September 25. Surgery of Colon and Rectum, one week, starting September 11. Esophageal Surgery, one week, starting October 16. Breast and Thyroid Surgery, one week, starting October 2. Thoracic Surgery, one week, starting October 9. Gallbladder Surgery, ten hours, starting October 23. Fractures and Traumatic Surgery, two weeks, starting October 9. Basic Principles in General Surgery, two weeks, starting September 11.

GYNECOLOGY—Intensive Course, two weeks, starting September 25. Vaginal Approach to Pelvic Surgery, one week, starting September 18.

OBSTETRICS—Intensive Course, two weeks, starting September 11.

MEDICINE—Intensive General Course, two weeks, starting October 2. Gastro-enterology, two weeks, starting October 16. Gastroscopy, two weeks, starting September 11 and October 23. Electrocardiography and Heart Disease, four weeks, starting October 2.

DERMATOLOGY—Formal Course, two weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 25. Cystoscopy, ten day practical course, every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES

TEACHING FACULTY

Attending Staff of Cook County Hospital

Address: Registrar, 427 S. Honore St., Chicago 12, Ill.

NEW YORK UNIVERSITY
POST-GRADUATE MEDICAL SCHOOL
(A Unit of the New York University-Bellevue Medical Center)

The following part-time courses will be offered by the Post-Graduate Medical School during the year 1950-51. These courses will include lectures, case demonstrations and clinical observation, as well as discussion of the recent advances in the various fields.

BASIC SCIENCES

BIOCHEMISTRY
Mondays — 7 to 9 p. m.
September 25, 1950, through March 19, 1951

MICROBIOLOGY
Tuesdays — 7 to 9 p. m.
September 26, 1950, through January 23, 1951

PHYSIOLOGY
Wednesdays — 7 to 9 p. m.
September 27, 1950, through March 7, 1951

PATHOLOGY

GYNECOLOGICAL PATHOLOGY (for specialists)
16 sessions — Wednesdays — 11 a. m. to 1 p. m.
September 20, 1950, through January 3, 1951

SURGICAL PATHOLOGY (for specialists)
30 sessions—Tuesdays and Thursdays 2:30 - 4:30 p. m.
September 19 through December 28, 1950

GENERAL PATHOLOGY
12 weeks — Mondays through Fridays 9 a. m. to 12 m.
September 25 through December 15, 1950

RADIATION PATHOLOGY
24 sessions—Mondays and Wednesdays
12:30 - 2:30 p. m.
October 2 throught December 20, 1950

PATHOLOGY FOR SURGEONS
(Given at Lenox Hill Hospital)
12 sessions—Mondays and Thursdays 8 - 9 p. m.
October 16 through November 27, 1950

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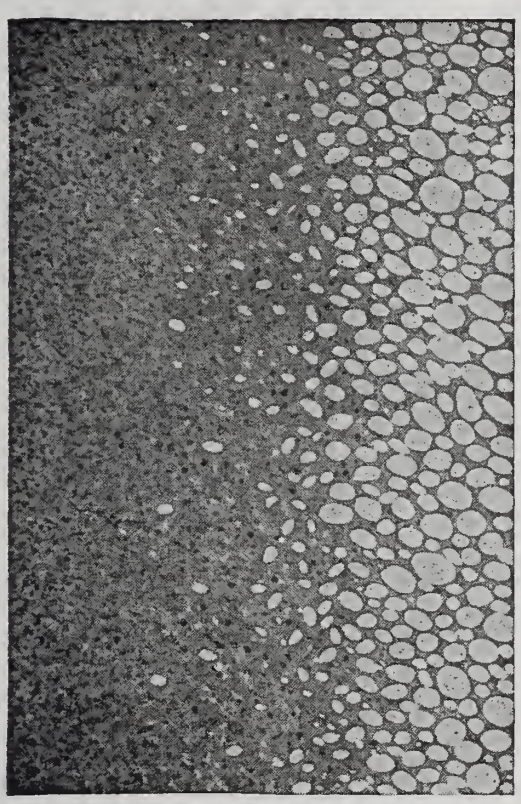

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SPEAK NOW . . .

No matter how you phrase it, the alternative of such a time cannot be denied. This is a time that requires positive action on the part of the medical profession. If this action is not forthcoming, doctors cannot reasonably complain of the consequences.

This is a year in which the American people elect Senators and Congressmen to represent them in Washington. Under our system of government, it's up to every citizen to work for the success of candidates in whose views he believes. Only through active effort can we have good government.

This responsibility is now squarely before all doctors. If they are to be well represented they must work, and they must start now. Doctors, their families, their friends, all they can influence must be registered. On election day this November,—it's up to the doctors to help by voting for their preferred candidates.

There is only one way to preserve American freedom—medical freedom—under our democratic process. That way is the voting way. It's the best way ever devised, but it poses responsibilities. These are responsibilities no doctor can afford to sidestep; responsibilities that need meeting now.

In every human undertaking, there comes a time for action, a time for decision. You can describe it in the language of the marriage service: "Speak now, or forever hold your peace." Or to put it less elegantly: "Put up or shut up."

PRIVACY, PATIENTS AND PRACTITIONERS

If a sound track recorded the conversational buzz in a staff room, the playback might be surprising, perhaps embarrassing. An objective listener would notice that here and there a doctor was astonishingly free with the use of names. No malice is intended, of course, but the occasional practitioner finds it hard not to boast by mentioning the name of an important patient. Or he seeks to lend reality and versimilitude to a story by interspersing it with real names. As evidence of this breakdown of privacy, consider how hard it is for a physician to conceal his *own* illness. Though he tells it only to his chosen medical adviser, somehow the story is soon all through the hospital that Dr. A. had a coronary attack and Dr. B. has gall stones and Dr. C. is getting ACTH injections. And if privacy is not respected in this situation, it is jeopardized in others.

Privacy in some respects, is an old fashioned virtue. It seems curious that in an era when towns were small and everybody knew everybody else, privacy was more obtainable than it is in this age of mass anonymity. The doctor dreaded being known as a gossip. Indeed, he could not remain in practice if he acquired a reputation for being leaky. And one wonders what has happened to make the habit respecting confidences seem so unimportant today. It is certainly not any moral or ethical deterioration within the profession. More likely it is the growing shadow of the personnel folder,—that rapacious file into which is poured so rich a variety of intimate data. A child has a personnel folder in the school building and in it are facts about his vaccination, his I.Q. and his relations with his parents. And this grows with each year of school. When he seeks employment another file appears in which are entered his height and weight and his scars and his aptitude test scores. In the Army a new and even bigger file is created. If he seeks government employment (and millions of us do) the insatiable folder accumulates data about his chest x-ray and his loyalty and his medical history.

When he wants insurance or a job, more questionnaires are filled out. Thus the file gets larger. And he has numbers—all sorts of numbers. Social security numbers and Army serials numbers, and employment badge numbers, and license numbers, VA claim numbers and insurance policy numbers, Blue Cross and Blue Shield numbers, numbers with A before them and numbers after B and also C numbers and D numbers. His finger prints are filed with the Army or the civil service, and his signature is known to the motor vehicle agencies and appears on his communtation tickets. Every hospital admission means another chart and, incidentally, another number. There are special dossiers with every job obtained (employment record), every lay-off (unemployment benefits), every illness (cash sickness benefits), every accident (accident insurance), every change of residence (voting register).

One can scarcely blame the doctor for feeling that privacy is a lost pleasure, for how can there be privacy when a hundred file cabinets contain all sorts of intimate data about you and me? Within each agency's framework, the privacy of the file cabinet is, no doubt, scrupulously preserved. But when ten clerks have access to each cabinet, and a hundred cabinets contain our folders, then a thousand persons can pull us out of hiding and read the score aloud. Privacy is for prudes, it appears. Why keep quiet about Mr. X's tuberculosis when it is known to the orderly in the plant infirmary, to the attendant in the chest clinic, to the adjuster, the agent, the clerk and the attorney in the office of his health insur-

(Continues on page 389)

ORIGINAL ARTICLES

THE CANCER PROBLEM

Nicholas G. Demy, M.D., Plainfield, N. J.

The most serious medical problem today is cancer. The infections and inflammatory diseases are being progressively checked by antibiotic, hygienic and public health measures. Even the most stubborn of these—tuberculosis, syphilis and subacute bacterial endocarditis—show promise of being reduced to minor infections. Cardiac disease is the leading statistical cause of death but aside from rheumatic heart disease, it is a blessing which occurs mostly at an advanced age and rather kindly snuffs out the candle.

This is not so with cancer which is as universal as life but as insidious as death. This year 200,000 deaths from cancer are expected. This statement is unreliable since cancer is the most underdiagnosed cause of death and the actual number is greater. Furthermore, these deaths do not indicate the true number of overall cases because there is a considerable salvage in all forms of cancer except those of the gastro-intestinal tract, lung and embryonal origin. For instance, between 70 and 90 per cent of skin cancers, 20 per cent of *all* cervix, 20 to 40 per cent of *all* breast and a still higher ratio of laryngeal malignancies show five-year survivals. Study of mortality statistics gives no correct idea of the distribution of cancer in the human body, nor an adequate appraisal of results from improved diagnosis and treatment. Thus, many arrested cancer patients die of heart disease incident to old age. Our statistics come from national or international centers of surgery and radiation therapy which are often the ports of last call for desperately advanced cases and therefore do not include the many unpublished cures by the general surgeon and radiation therapist.

The widely prevailing occurrence of neoplasms in nature excludes the effect of specific diets or other environmental exposures which are peculiar to civilization alone, although many important exceptions are noted and the last word about etiology has not yet been said. For instance, during the early 1900's, Metchnikoff noted that the Balkan peoples lived to be 80 and 90 in greater numbers than elsewhere. Their diet consisted mainly of dairy products, fermented mare's milk and sour milk. He asserted that the aging process was due to the "toxins" from the colon bacillus, and that when the latter was displaced by the lactobacillus acidophilus the ravages of senility were delayed. Later, someone else pointed to the large number of deaths from cancer among the Balkans, and attributed these to the milk diet. Both of these conclusions were naive but the milk factor has had a curious revival in the work of Bittner to be mentioned later.

Age, sex, geography and customs do play a part, but only to increase the number of cases rather than as prime causes. Cancer of the penis is a striking example of custom-induced neoplasia. In Jews (who are circumcised at birth) carcinoma of the penis rarely if ever occurs; in Mohammaden Hindus (who circumcise at 13 years of age) carcinoma of the penis occurs but not too commonly; in Gentiles and Buddhist Hindus who do not practice circumcision, cancer of the penis is relatively common. Phimosis is present in over 70 per cent of the cases, so that long-continued irritation by the carcinogenic smegma is believed to be a factor. In this connection may be mentioned the rarity of cancer of the cervix among Jewish women, though 96 per cent of all women with cervical cancer have borne children. The trauma of childbirth may be a predisposing factor but the addition of a carcinogenic agent (such as the smegma of uncircumcised males) may be the inciting factor. This may be far more important than chronic irritation

which has never been proved to be carcinogenic by itself. This cannot be attributed to racial immunity of the Jews since cervical cancer is infrequent among Fiji women whose husbands are circumcised at puberty, whereas Hindu women living in the Fiji Islands have a cervical cancer incidence eight times greater. These data constitute persuasive reasons for circumcision at birth of all males in order to reduce both penile and cervical carcinoma to at least one-sixth of its present level.

Cancer of the female reproductive organs is so common that its comparative rarity elsewhere in the female body is thought to be due to an immunologic response. The following table (showing deaths from cancer in sites common to both) shows a marked difference in sex incidence:

Site	Male	Female	Ratio
Lip	849	20	42:1
Tongue	3,225	217	15:1
Mouth and tonsil	1,706	143	12:1
Pharynx	1,075	221	5:1
Stomach	18,876	9,243	2:1
Bladder	2,668	675	4:1
Lung	6,821	690	10:1

This preponderance of males is even more evident since our population has an excess of females in the cancer-age group. However, when all cancers are included, 270 females per 100,000 population, but only 230 males develop cancer.

The conclusions to be drawn from data based on factors peculiar to diets and civilization are obscure since carnivorous cats and dogs have a large variety of tumors; herbivorous horses are no less prone to neoplasms; spontaneous tumors occur in fish, and plants develop "crown galls" and other growths analogous to cancers in the animal kingdom.

The word "cancer" includes all forms of malignant growth in the same sense that inflammatory diseases include such infectious processes as tuberculosis, syphilis, pneumonia and septicemia. Squamous cell carcinoma of the skin, however, is no more related to squamous cell carcinoma of the lung than tuberculosis is to syphilis. There is then no logic in speaking about a single cause of and a single cure for cancer.

The methods used to cope with inflammatory diseases have to date failed utterly in cancer since the latter is unlike any other biologic process short of normal cellular phenomena. This failure has led to many myths about the cause. Cancer is one of the last outposts of metaphysics in medicine. All other phenomena have some understandable purpose of growth, function, controlled repair and reproduction. Cancer cells seem to have forgotten everything but senseless never-ending reproduction. It might be argued that an invading bacterium is a normal biologic phenomenon with the very understandable purpose of nourishing and perpetuating itself even to the death of the host but that methods have been found to stop it in its tracks. This comparison with the cancer cell is superficial in that profound differences of origin, metabolism, stroma and substrate exist. The answer may well lie in some small difference between the nuclear metabolism of the cancer cell and the normal cell from which it arose.

Experimental production of tumors, their natural occurrence as occupational and environmental diseases, and statistical observations in the large tumor centers have given us a great body of knowledge concerning the cause of *some* cancers. No one theory and no one known cause supports all the clinical observations in all forms of cancers. Historically, there have been only four theories which have had any serious merit—those of Virchow, Thiersch, Cohnheim and Ribbert.

VIRCHOW'S THEORY

Virchow felt that chronic irritation (not infectious in character), was the cause. In this, he was partly right. We know now that the irritant must be specific, the field prepared, and a long latent period must elapse before the appearance of a malignant change. Thus, some oils, tars and concentrated sugar solutions which are bland or soothing to the skin are highly carcinogenic whereas acids and alkalis which are caustic, never produce carcinoma. Cancers appearing in old burns and scars, in the lip and tongue of luetics, in the skins of sailors, farmers and early workers in x-ray and radium, have all been preceded by a long

latent period which has followed the initial irritation. The incidence of skin cancers among Texans is several times greater than among residents of Michigan, and is in direct proportion to the amount of daily sunshine. The growing list of occupational cancers may be cited: cancer of the bladder from aromatic amines; cancer of the lung in cobalt miners of Germany which has been known for 500 years though the non-mining population in the same vicinity has had only a normal incidence; the same high rate is present in the pitchblende and arsenic miners of Austria. A recent survey showed an even higher frequency among the population of the dirty, heavily industrialized section of Chicago whereas the incidence in the clean residential section was notably lower. A specific, air-borne carcinogen is likely wherever the incidence is high.

Cancer of the scrotum was common among the chimney-sweeps of Dickens' time but is rare now. Cotton-spinner's cancer is still as common, however, as in the early days of the industrial revolution. We are all familiar with the watch-dial painters who manifested sarcoma of the mandible 15 to 20 years after their exposure to radium. An interesting example of the relation of irritation to cancer is among the Kashmirian natives who carry a basket of hot charcoal under their clothes for warmth. They develop carcinoma of the abdominal wall which is unknown in any other race. Leukemia is eight times more common among radiologists than among physicians in general.

Over 200 unrelated chemical carcinogens are known. Dozens of viruses and parasites produce cancer in animals either experimentally or spontaneously. Cancer of the bladder among Egyptians is associated with the ova of Bilharzia deposited in the bladder wall; cirrhosis of the liver and fluke infestation in African Negroes and Chinese is followed by cancer though primary hepatoma is otherwise a rare tumor.

Certain endogenous factors, the sterols, enzymes, estrogens, androgens and other hormones are suspected of being carcinogens. Theoretically, long-continued stimulation by androgens results in prostatic hypertrophy or carcinoma. Treatment with stilbesterol produces temporary regression of the primary tumor as well as the metastases. However, there are at least five authentic cases of breast carcinoma in males who have had long and intensive stilbesterol therapy for prostatic carcinoma, with increasing number of reports of gynecomastia and proliferation of breast tissue among males engaged in manufacture of stilbesterol and other estrogens. Experimental work and clinical observations have fairly well established the role of estrogens in cystic hyperplasia of the breast as a precancerous condition. It is much more common in nulliparae in whom monthly stimulation and suppression of breast function without drainage may result in cysts, papillae and dilatation of the ducts.

When the mammary ducts of an adult rat are tied off and rapid breeding is forced, the incidence of breast cancer (even in resistant strains) is markedly increased. In contrast, the cow which has the most over-worked mammary glands in the world never develops cancer of the breast. Stasis is not the only factor, for if estrin is injected into mice of "low cancer" strain, a large proportion of breast cancers will result; if, however, the ovaries are removed from young mice of high cancer strain, cancer never develops in the immature breasts. A clinical application of hormonal effect is the use of testosterone in premenopausal women with carcinoma of the breast and metastases.

By far the most significant observation has been noted by Bittner, following the work of Maud Slye. Several strains of mice have been obtained by generations of selective inbreeding, one of which is highly resistant to breast cancer, the other in which nearly all the parous females over ten months develop spontaneous mammary tumors.

When new-born females of "high-cancer" strain mothers are removed from the litter and suckled by "low-cancer" strain mothers they do not develop breast tumors. When "low-cancer" strain offspring are suckled by "high-cancer" females the incidence of breast cancer is greatly increased. Bittner concluded that three factors were responsible: (1) an inherited genetic susceptibility; (2) a hormone factor affecting the breast during lactation; (3) a breast-cancer producing substance, the

nature of which is not yet evident but which answers to the properties of a virus. The milk factor will not incite cancer if the genetic substrate and hormonal excitation are not present. The question arises whether these factors also obtain in human breast cancer since this might constitute an argument against nursing. One of the standard questions now being asked in large cancer centers is whether the patient had been breast or bottle fed, but it is questionable how valid such statistics will be since man is a hopeless hybrid, and no human milk factor has yet been discovered.

COHNHEIM'S THEORY

Cohnheim had a theory of cell-rests dealing with supernumerary tissues and embryonic misplacements in adrenal, thyroid, parathyroid, pancreas, undescended testicle and mucocutaneous junctions. This organ susceptibility has been noted in "cancer families" wherein numerous members may die of cancer of the lip, uterus, gastro-intestinal tract, eye or skin. Occasionally, homologous twins will develop identical tumors in the same site. Inclusions of embryonic tissue in the midline of the body and at the lower end of the vertebral column are said to be responsible for teratomata and other tumors in those sites. However, the theory is not valid in the vast majority of cases.

RIBBERT'S THEORY

Ribbert followed Cohnheim with a "tissue-tension" theory which stated that cells normally stop growing not because they have lost the power of growth but because they are limited by certain chemical organizers and local environment. When the capsule of a tumor is broken, the cells grow more rapidly because mechanical restraint has been removed. Functional activity is also a factor in limiting tissue growth. Tumor cells have lost the habit of work and assumed that of growth without limit. Many but not all tumors have no functional activity.

The theory appeared strengthened by experimental observation that when the base of a benign growth was cauterized, a malignant change supervened. A similar occurrence was noted clinically when a pigmented mole was disturbed by incomplete removal and a fulminating melanoma followed. Nothing had been added to the cells but something may have been removed from the environment which ordinarily exerted a restraining influence. Years ago when Jacques Loeb notched the leaf of a Bryophyllum plant, normal healing occurred so long as the leaf remained on the stem. If the leaf were removed and then notched, small leaves and tendrils grew from the edges of the notch. Abnormal proliferation occurred when the growth restraint in the stem was removed. The theory has many flaws and is not now a serious contender.

THIERSCH'S THEORY

Thiersch, in 1865, stated that malignancies do not arise from a single cell or minute focus but from multicentric areas in a widely prepared field. Recurrences were due not to tumor tissue after excision but from new areas of cancerous change in a tumor-formative field. This idea conforms in many respects to the modern concept of carcinogenesis but did not receive attention due to acceptance of Cohnheim's and Ribbert's theories.

Cheatle and Cutler have shown that local excision in breast cancer is surgically unsound because numerous microscopic malignant foci were present in a single breast and that excision of the clinically evident nodule only was followed by "recurrence" or "metastasis". Many examples in support of this observation may be cited even though a genetic factor is present in some: multiple polyposis of the colon, xeroderma pigmentosum, cystic hyperplasia of the breast, retinoblastoma and melanoma.

EMBRYONIC TUMORS

Most ordinary tumors of adult life arise only after prolonged exposure to a carcinogenic substance, which may be (1) chemical, as arsenic, the phenanthrene hydrocarbons, hormones, sterols; or (2) physical, as burns, roentgen and ultraviolet rays. In animals, at least, numerous tumors have been produced by viruses and parasites. None of these factors, however, can be responsible for embryonic tumors, some of which arise and metastasize widely during intra-uterine life or shortly after. Tumors of embryonic or fetal life are less

mature and more malignant, and correspond with the formative stage of an organ. Immature neuroblastic tissue is scant in the sympathetic system soon after birth; thus, most neuroblastomas appear within three years. Retinal differentiation is complete at or soon after birth and the vast majority of retinoblastomas are clinically evident before the age of three. Cerebellar development is nearly complete at one year and medulloblastomata arise almost entirely in the cerebella of young children, though they are also common in other parts of the brain in adults. Renal tissue maturates shortly after birth and the vast majority of Wilms' tumors are discovered before three years. The same is true of embryonic hepatic tumors. Teeth maturate during adolescence and early adult life which is the time of appearance of adamantinomata in the paradental tissues. Osteogenic sarcomata and malignant giant cell tumors occur at the metaphyses during the period of greatest skeletal growth and before closure of the epiphyses has occurred. Embryonic tumors which appear in childhood are clearly not due to a long acting carcinogen on a prepared field. Some such thing may happen in embryonic tumors occurring in adult life, and various enzymes, organizers and sterols have been postulated as exciting agents but all this is highly speculative.

The interchangeability of mesenchymal tumors, their frequency during early life, and the kinship of the sarcomata indicates an embryonic potency. The young fibroblast may metamorphose into any one of the connective tissue elements, and the classification of sarcomata as fibro-rhabdo-osteo-reticulo-or myxosarcoma, with any combination in any sarcoma points to the primitive multipotent nature of the tumor.

The lymphoid tumors, as examples of sarcomata, show an even greater chaos in terminology, though the confusion is slowly being resolved. Giant follicular lymphoblastoma exhibits a benign phase which may last fifteen years and may then translate into Hodgkins disease, leukemia or lymphosarcoma. Some pathologists feel that giant follicular lymphoblastoma may be the parent lesion from which all the lymphomata arise.

CANCER DETECTION

The publicity given the cancer problem has led many people into thinking that early diagnosis is the answer and that a cure will follow if enough dollars are collected; that the problem is of the same nature and magnitude as the atom bomb, and can be solved by the same methods. This reasoning is spurious; cancer is not a problem of material and money, but of knowledge.

Cancer publicity stresses getting the patient to the doctor early, the assumption being that the doctor has a touchstone which will separate cancer from less deadly diseases. But we know that many different cancers arise in any tissue and present no *known* special metabolic differences from the ordinary phenomena of health and disease until too late. Thus it appears that no universally applicable cancer-specific test will ever be prepared. So far, no toxin, no product of metabolism, no pathogen, no protein or antibody peculiar to cancer in general has been discovered.* If any test which depends on complement-fixation, cutaneous reaction or antigen be found, it will be just as specific for, let us say, a Wilms' tumor or leukemia or osteogenic sarcoma as the Wassermann is for syphilis, the Widal for typhoid or the tuberculin for acid-fast, barring anamnestic confusion.

With our present methods and the nature of malignant neoplasia, early diagnosis in such major lesions as cancer of the stomach, lung and ovary is a surprisingly lucky accident. Only three months need elapse between a negative roentgen diagnosis and roentgen demonstration of gastric cancer in the same patient. Since the symptoms of cancer are notoriously vague and non-specific, routine x-ray examination of the stomach in all persons over 45 years has been proposed. Several such mass fluoroscopic and fluorographic studies have been done on persons free of gastric complaints but the number of unsuspected cancers found (2 in over 8000 cases) has not warranted the time, expense and medical talent consumed. Other surveys have shown that such projects would not be feasible under any system of medicine, no

* The thermo-labile blood proteins demonstrated by the Huggins test are *not* specific for cancer and may be evoked by non-malignant conditions.

matter how liberal and altruistic, since there are not enough radiologists and machines available for the usual load of sick, much less for screening the normal population.

The Papanicolaou test has been extended from cervix to lung, stomach, prostate and kidney tumors with variable success, for the positive findings are presumptive. Lesions which do not exfolliate cancer cells give a false negative. Furthermore, in organs such as brain, thyroid, lymph nodes, gall bladder, pancreas, liver and bone, no cells are accessible to any external orifice and biopsy is done only if the diagnosis is already suspected.

Therein lies the greatest fallacy and prime inadequacy of cancer detection programs. When the symptomless patient presents himself, where is the examining physician to start? We all depend on the patient's history for the first clue but even in such readily accessible cancers as the female breast in these days of cancer consciousness we see women with far-advanced lesions, incurable by any approach. In a review of failures to make an early diagnosis in breast cancer it was shown that the fault for late diagnosis lay with the patient in 74 per cent of the cases and with the physician in 26 per cent. What, then, can we expect of gastric cancer?

The problem of diagnosis can be stated thus: the symptoms appear too late and the patient does not present himself early enough; the limitations of simple physical examination will not detect the internal cancers soon enough no matter how early the patient presents himself; special examinations such as x-ray and biopsy follow only on strong suspicion of cancer in a certain region. These methods themselves have limitation and errors, and are not the last word in diagnosis. Greene has overcome some limitations of biopsy with transplantation of suspect tissue into the anterior chamber of the guinea pig's eye. Only malignant and embryonal tissue will give a positive "take".

THE QUEST FOR A CURE

The search for a universal cure seems as illusory as for a universal diagnostic test. No field in medicine is so hospitable to quacks and is so cluttered with the wrecks of discredited treatment. A pessimistic attitude toward each new and eagerly heralded treatment is justified even though the next biochemical discovered be the elixir of life itself.

The treatment for prostatic cancer is not the same as for cancer of the uterus or any other neoplasm. The prognosis varies from a possible complete cure in a Stage I cancer of the cervix or breast to inevitable death in acute leukemia. A localized tumor is potentially 100 per cent curable by surgery, but there is no detectable change in the tumor field to define the limits of tumor growth for the surgeon or the radiologist. Moreover, we have only a dim idea of what constitutes a lethal tumor dose, and with many radioresistant tumors the difference beween a minimum lethal dose and normal tissue-death is so small that no cure can be accomplished without serious injury to the patient.

The present hope lies in search for chemotherapeutic agents such as the nitrogen mustards in Hodgkins and in certain anaplastic carcinomata; urethane in leukemia; radio-active isotopes in functioning thyroid tumors and in polycythemia vera; hormones in prostatic and mammary carcinomas; and in supervoltage radiation from betatrons and the like. The race is on; so far, the isotopes have been disappointing and only radio-active cobalt shows signs of supplanting radium. In the last five years, greater progress has been made in radiation therapy than in the previous 45. We are learning what constitutes a lethal dose for various tumors and how best to deliver it. But this method will never be the answer to the cancer problem for although the primary tumor can be consistently sterilized with x-rays or radium more effectively than by surgery in some cases, death from metastatic extension has been as consistently discouraging. The imminent discovery of a chemotherapeutic agent will make obsolete hardware of deep and supervoltage x-ray therapy equipment. There is feverish activity in many laboratories working on nuclear toxins, folic acid antagonists, enzyme and metabolic inhibitors. The aim is to find a difference between the biochemical behavior of cancer and normal cells, and to in-

terfere with nucleic acid synthesis so necessary to the rapidly dividing cancer cells.

Cancer is a more subtle, insidious imitator than syphilis but the sequence of etiology, diagnosis and therapy will not be so direct and logical as with syphilis. It is more likely that cures for the cancers will be found long before causes or specific tests are discovered. We may describe the histologic and metabolic characteristics of cancer but we will not know its essence until we have the answer to Tennyson's

"Flower in the crannied wall,
I pluck you out of the crannies,
I hold you here, root and all, in my hand,
. . . . but *if* I could understand
What you are, root and all . . . .
I should know what God and man is."

And it may be added, what cancer is.

The nature of cancer may well remain within metaphysics, for at present, the oncologist, the biologist and the poet are of imagination all compact.

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AN OPERATION FOR NON-SPECIFIC ALLERGIC RHINITIS

Herman C. Comora, M.D., West New York, N. J.

Some patients suffer from nasal bogginess that persists for long periods recurrently through the year. Sometimes this follows an ordinary cold; at other times, it comes on at the end of an acute or subacute sinusitis, and occasionally (in "low resistance" persons), it gives the impression of allergy because of continuous swelling, greyish edema of the nasal mucosa, excessive secretion and obstruction, accompanied by sneezing, headaches, asthenia, malaise and, generally, symptoms of upper respiratory rhinopharyngitis. In many of these cases the inferior turbinate is found in close contact with the floor of the nose. Antihistamines and ephedrine preparations frequently fail to alleviate the persistent edema or the symptoms of distress.

The following operation has, in my experience, afforded prompt and lasting relief to most of these patients.

The lower half of each inferior turbinate is anesthetized topically with a ten per cent cocaine adrenalin preparation. With a sharp septum knife, an incision is made along the inferior border of the turbinate from before backward, hugging the lower border of the bony turbinate. The mesial lower half of the mucosa and periosteum is elevated from before backward. With a nasal scissors, about three millimeters of the inferior border of the bony turbinate is resected with the attached lateral mucosa and periosteum. The mesial elevated mucosa is now used to cover the entire denuded bony area, moderate pressure is now applied to the replaced flap and the other side treated in a similar manner.

The packing (consisting of a rubber finger cot filled with one-half inch gauze) is used for pressure, which on removal after two days causes a minimum of bleeding or disturbance of the flap.

A secondary similar operation may occasionally be advisable where an insufficient amount of turbinate was removed the first time.

In a series of one hundred cases over a period of fifteen years, I have had a few recurrences which subsequently proved to have specific allergic reactions of some kind or another. Five patients subsequently developed polyps or other nasal obstruction which necessitated further surgery. A number of these patients moved away and no follow-up could be accomplished on this small group.

This simple operation is worth trying for intractable allergic rhinitis of a non-specific type. One of its great advantages is that no raw surfaces are left to granulate, scar or adhere to adjoining tissues. It is a simple office procedure and occasionally does away with the necessity for the orthodox septal resection.

317 Sixtieth Street

IMMEDIATE TREATMENT OF BARBITURATE POISONING *

USE OF ELECTROSTIMULATORY THERAPY

Theodore R. Robie, M.D., East Orange, N. J.

Picrotoxin is the usual drug given for barbiturate poisoning. Though often effective, it is a dangerous drug and may actually hasten death if given intravenously by unskilled hands. Actually there is no specific chemical antidote to barbiturates. What this treatment amounts to is, in effect, poisoning the patient with picrotoxin to produce an antagonism to barbiturates. But often the dose of picrotoxin needed to accomplish this is so great that convulsions may be induced. And then we have to give barbiturates to control the convulsions. This is manifestly an unsatisfactory way to treat barbiturate poisoning. We now have a better way.

Shortly after undertaking consultative responsibilities at the Veterans Hospital, Lyons, New Jersey, I had the privilege of observing the use of minimal dosage of undirectional electric diencephalic stimulation, as a therapeutic measure in certain psychoses and neuroses. While observing these treatments it became apparent that, following the stimulatory treatment administered to patients who had been anesthetized with sizable dosage of intravenous sodium pentothal, the *patients awoke* and talked *almost immediately* following cessation of the electrostimulation, or "psychostimulation", as we have called it. This observation (that pentothal anesthetized persons awoke very quickly as a result of minimal dosage cerebral stimulation by electricity) convinced me that this method could be used to awaken individuals who had ingested a lethal dose of barbiturate, accidentally or with suicidal intent. Since barbiturate overdosage is rapidly increasing in recent years as a cause of suicide, and since the treatment of barbiturate poisoning taxes to the utmost the physician's therapeutic skill, any method of neutralizing the drug should be a welcome addition to our armamentarium for preserving human life.

In my discussion of Dr. Hirschfeld's paper[1] on non-convulsive electrostimulation, I rejoiced in his establishing the fact that therapeutic results could be obtained without the production of a convulsion, and his corroborating the fact that electro-encephalo-therapy has become one of the most important tools in the hands of psychiatrists. We can now produce a constructive therapeutic response in carefully selected cases, without the threat of fracture complications, which heretofore interfered with our patient's clinical progress, whenever they occurred. I then stated:

> "Now I have come to one of the most important discoveries that has come out of this research of Dr. Hirschfeld's. As is so often the case, the by-products of some new chemical process or some new invention or some new discovery in medicine, may prove to be even more important than was the original purpose of the therapeutic regimen. Such may prove to be the case here. Dr. Hirschfeld has shown us a very simple method of quickly overcoming barbiturate poisoning. This is shown day after day at the Veterans Hospital and in my own practice, where one sees patients who are very deeply narcotized by heavy dosage of pentothal, brought to a semi-wakened state very rapidly after the current is applied, and by carefully controlled continued application can be brought to a fully wakened state."

This principle certainly could be applied in any general hospital when a case of barbiturate poisoning was admitted, and would eliminate the long and trying experience of giving repeated intravenous doses of picrotoxin or amphetamine, as well as the prolonged vigil while the question of the patient's survival is being resolved. Furthermore it should prevent the cerebral or cerebellar damage that may occur in patients who do survive, but who have remained in barbiturate produced coma for prolonged periods. Since death from barbiturate poisoning is usually the result of paralysis of the respiratory center, the immediate amplifi-

* Read at the March 14 (1950) meeting of the New York Neurological Society.

1. Presented before the New Jersey Neuropsychiatric Association on April 20, 1949.

cation of respiratory movements from the beginning of electrostimulation, gives the doctor an increased sense of security that he may save the patient—a very important aid in dealing with distraught relatives who had, perhaps, seen the shallow or almost absent respirations before treatment.

Following this suggestion, a number of psychiatrists including the author, tried out the method, when barbiturate poisoning cases were admitted in coma to local hospitals. They all found that the method works, simple as it is. Thus we have discovered one more sphere in which the recently coined axiom is again true: "Today—electricity is treatment!".

A number of psychiatrists have been meeting regularly as a research panel to study this whole question further, and I shall abstract for you some of our joint observations. First, one of my own.

A woman of 52 was admitted to the hospital in coma. The medical attendant thought that she was in diabetic coma, as her blood sugar was 307. She received an anti-diabetic routine. After 40 hours in the hospital she was still in coma (the duration was believed to be 44 to 46 hours), and her blood sugar had become normal *via* insulin and other treatment. She also had pneumonia, but temperature had been reduced to normal by penicillin. When I examined her at 11 a. m. she was still in deep coma. She had loud sterterous breathing with no reaction to pin prick. The nurse said she had not roused at any time. Another hour was consumed in locating her family and securing their written permission to carry out the treatment. She was believed to have taken an overdose of "sleeping pills" she was known to have had in the house.

During the time thus consumed, she began to show some degree of rousing. I administered the electrostimulatory treatment starting with 3 milliamperes and gradually raising to 7 for twenty seconds. Following this she talked and reported having swallowed 16 seconal capsules[2] approximately 47 hours before. She immediately protested against being wakened and followed this with pleading "Oh! Please put me out of my misery". She soon began to lapse into lethargy and was given electrostimulation again, this time 5 to 7 milliamperes for 60 seconds. Very obvious increase in muscular activity around the face and neck and increased depth of respirations was apparent during the stimulation. On cessation of stimulation this time it was obvious she was awake to stay for she went on at length reiterating her melancholy trend, muttering: "Oh! If I only could die! Doctor, please let me die for my own good. Please! I'm in such misery!"

Since we were dealing with involution melancholia, a course of electroshock therapy was started the following day. In retrospect one may say that judging from the experience of others who have used this treatment successfully, this woman could have been wakened from her barbiturate induced coma 24 or even perhaps 36 hours sooner, thus eliminating the anxious vigil that relatives maintained for so long, and eliminating the threat of the permanent brain damage that may occur from prolonged barbiturate effects.

A number of other psychiatrists[3] are using this method of wakening people who have taken overdoses of barbiturate. Dr. Arthur Colley of Plainfield tells me of this case:

A woman of 51, in an agitated episode of melancholia, ingested unknown amount of barbiturate, with suicidal intent. It was later learned that she had been saving up capsules for a year! Found in deep coma at 5:30 p. m., she was taken to a general hospital where medical measures were administered for five hours without effect. Dr. Colley was called in at 10:30 p. m. She was still in deep coma, with weak thready pulse, and respirations barely perceptible. In this case cerebral electrostimulation was started immediately. Only 17 minutes of stimulation were necessary, with the current at the five milliampere level, to initiate motor activity, i. e. spontaneous restless movements. Since this motor activity heralds a return to consciousness, the stimulation was interrupted. The patient then uttered a few unintelligible word sounds. She was then given another three minutes of stimulation, and following this, was sufficiently roused to talk intelligibly. While there was some residual drowsiness, it was possible to awaken her when desired and therefore no further stimulation was needed. She has done well on the course of electrostimulatory therapy administered since then.

I am indebted to Dr. R. E. Bennett of Trenton State Hospital for the following summaries of two cases he had treated by the Reiter electrostimulation method. Both were profound suicidal attempts.

The first patient, a white female, had taken about 35 grains of Seconal[2] and was in a profound state of narcosis. She had not responded to previous treatment. Cerebral electrostimulatory treatment was administered twenty hours after ingestion and within ten minutes she was in very light

2. Seconal is the Eli Lilly Company trade name.

3. Including Doctors Colley (Plainfield, N. J.), Furst (Newark, N. J.), Impastato (New York City), Larragoiti (Havana, Cuba), Bennett (Trenton) and Sagredo (Havana).

coma. In the light of our more recent experiences, if we had continued the treatment longer, we would have had her completely awake; as it was, we had her to the point where she could be roused. She enjoyed a normal sleep for approximately an hour and a half and then wakened spontaneously.

The second case was a white female who had swallowed 88 grains of phenobarbital and was admitted to the hospital five hours later. Treatment was started immediately. This woman was moribund and in the hospital the three doctors who saw her at the time anticipated that she would not live many minutes longer. Over a course of four hours she received 120 minutes of stimulation. She died two days later without having regained consciousness. Without this treatment, she would have been dead within a half hour of her admission to the hospital. There is, at least, a bare possibility that uninterrupted electrostimulation might have improved her chance of recovery—though it is obvious that the massive dose taken would make it unlikely that any measure could restore consciousness. Possibly added intravenous amphetamine would have increased her chance of recovery.

Although the number of cases reported is small, the evidence already accumulated has convinced our panel of 12 psychiatrists (who have gathered at regular intervals recently for pooled discussion of their experiences) that this method of treating barbiturate poisoning is efficacious and reliable, providing the patient has not ingested too large a dose. It is simple to administer, and there are no complicating sequelae of treatment. Moreover it is possible for any one who so desires, to see the method in operation any day, without waiting for an actual suicidal attempt to enter the hospital on which to try it out. I refer here to the patients receiving electrostimulatory therapy, instead of electroshock therapy. There are various types of mental disorders for which this less radical therapy may be applied. and one has to use substantial doses of pentothal[4] intravenously to produce anesthesia before the current is applied. The pentothal[4] anesthetized patient may sleep in deep coma for 1½ to 3 hours or even longer. It is astonishing to see a patient so anesthetized, and in deep coma, awaken and talk normally immediately following cessation of stimulation for as short a period as two or three minutes.

The use of this apparatus at the Orange Memorial Hospital brings to light this further interesting phenomenon: sodium pentothal is administered intravenously in anesthetizing dosage before the treatment is given. This is necessary because the electric current, mild as it is, is very irritating and painful, unless the patient is anesthetized. The interesting finding is this: if as little as 3½ to 4 grains of pentothal is successful in anesthetizing, the patient will be returned to consciousness relatively quickly by electrostimulation. Therefore only a short period of electrostimulation is possible, requiring only 40 to 70 seconds. If on the other hand, the patient requires 6 to 8 grains for anesthetizing, electrostimulation can be carried out for a longer period of time without protest and resistance on the patient's part, that is, for as long as 3 to 4 or even 5 minutes. But, here is a finding of considerable significance: if we start with 2½ or 3 milliamperes, the dosage has to be reduced at a rate of about one milliampere per minute, graduated down to about a half a milliampere. This is all the dosage the patient can tolerate without returning to consciousness during the last minute of a 3 to 5 minute treatment session.

Thus, we have here a rough measure (which, perhaps, could be calibrated more accurately) of the return to consciousness threshold via electrostimulatory therapy from barbiturate-induced coma.

The method of treatment is simple. The Reiter CW-47 Electrostimulator is used, the same apparatus, in fact, that we use, applying a higher dosage, for administering convulsive therapy. The current is turned on at two or three milliamperes. It is maintained at this level, raising or lowering the dosage as indicated by the patient's reactions. One can see muscular twitchings: fine jerking or wavy motions, around the forehead, face and neck almost immediately, unless the coma is extremely deep. Very soon after stimulation is started, an increase in the depth of respiratory movements will be noted. In relatively light coma, these muscular movements will increase in intensity and continue so long as the current is applied. After a given period, the current can be turned off to see whether the pa-

4. Pentothal is the trade name for the Abbott Laboratories brand of thiopental.

tient has wakened. As a rule, when getting close to a waking state the patient will writhe a bit or may utter guttural noises of protest. Audible words are not articulated under electrostimulation. But the cerebral irritation which the patient is experiencing, is perfectly obvious from the wincing and unhappy facial contortions. These grimaces become accentuated the closer the patient gets to consciousness as the barbiturate coma is slowly but steadily nullified by the electricity passing through the brain.

It is imperative that treatment be instituted early, otherwise death will occur from terminal bronchopneumonia or atelectasis. Any method that resuscitates the patient in the shortest possible time has a greater chance of preventing this secondary complication.

Cases of barbiturate coma should be treated in a hospital. However there may be factors that prevent this. Under such circumstances the electro-stimulatory therapy can be administered in the home, since the apparatus is easily transported. The doctor must be prepared to meet emergencies when and where he finds them; barbiturate poisoning is no exception.

CONCLUSIONS

1. Suicide and suicidal attempts by ingesting large doses of barbiturates have markedly increased in recent years.

2. The chemical antidotes available have been disappointing. They fail to revive a considerable proportion of patients.

3. A method which offers hope of producing recovery in a large proportion of cases and which is simple to administer, is now at hand. This is electrostimulation therapy.

ADDENDUM

This addendum is presented because of significant developments following the submission of this paper to the JOURNAL.

A resident had been instructed in the technic of using the Reiter electrostimulator while assisting the author with electroshock treatments. A woman was admitted to the hospital following an overdose of barbiturate and the resident was unable to locate the author at the time. Although he had little confidence in the machine for this purpose, he went ahead with stimulation. He used it for only a few minutes, because, in his words, "the woman began to waken quickly". In the light of subsequent observations it is obvious that she began to "waken quickly" *because* of the electrostimulation—short as it was.

When electrostimulation is used as a therapeutic modality when sodium pentothal is given as anesthetic in doses ranging from 4 to 9 grains intravenously, patients waken after two, three, or at most four minutes of electrostimulation. Yet these doses cause slumber for a number of hours when no electrostimulation is given.

Further and stronger clinical evidence of this observation came from treatment of a patient who had ingested 18 grains of barbiturate on top of a considerable quantity of alcohol. She was found in a deep, unrousable coma; limp, with pin point pupils. She was becoming increasingly cyanotic with shallow respirations, and was observed for an hour while the coma deepened. She was roused to a return of partial motor resistive consciousness in less than five minutes by the Reiter electrostimulator, using a dosage level of only 2 milliamperes and back to a fully talking stage of consciousness following less than ten minutes of total electrostimulation time.

In our thinking on this matter of suicidal attempts, in the midtwentieth century, let us keep in mind these interesting facts: (1) There has been a considerable decrease in the crude suicide rate in recent years. A 25 per cent reduction occurred during the six year period ending in 1947. This corresponds directly with the era in which electroshock therapy came into use for "melancholy" mental disorders (which may eventuate in suicide), compared with the average suicide rate during the decade previous to the introduction of electroshock therapy; (2) Although the net suicide rate has decreased, there has been during the same period, a striking increase in the number of suicides resulting from barbiturate poisoning. Deaths from barbiturate overdosage have been increasing rapidly each year. The statistics are astonishing.

A comparison of the year 1943 with 1945 shows a 75 per cent recognized increase in barbiturate fatalities in this country during the brief span of two years. Although the Medical Examiner's office in New York City, reported only 42 deaths from barbiturates in 1939, the number had leaped to 197 only five years later. These data are minimal compared to the extraordinary figures reported from Los Angeles where the 1947 deaths due to barbiturates were 677 per cent higher than those in 1944! And we have reason to believe that the actual number of deaths is considerably higher than is shown by the official statistics. This makes it obvious that a method so simple to administer, and which assures return to consciousness in most cases, within a relatively short period of time, will help not only in reducing the total death rate today, but will at the same time reduce still further, the net suicide rate. Patients resuscitated can then be administered electroconvulsive therapy to eliminate their melancholia. One writer recently pointed out that this fashion of suicide will continue to spread unless heroic measures are adopted to combat it, and this therapy is one such means.

144 Harrison Street

PREGNANCY COMPLICATED BY SUBARACHNOID HEMORRHAGE

CASE REPORT *

David B. Gershenfeld, M.D., and Lewis E. Savel, M.D., Newark, N. J.

Subarachnoid hemorrhage as a complication of pregnancy is rare. Recently Garber and Maier † reviewed the literature and found only twenty cases. They reported three additional ones making a total of twenty-three. We are reporting a case of primary subarachnoid hemorrhage which appeared clinically in the postpartum period.

A 24-year old white gravida 1, para 0, was first seen in the third month of her pregnancy. Family and past histories were irrelevant. Menarche had occurred at 13 years with periods of 4 days' duration, every 29 to 31 days, with moderate flow and no pain. Physical examination was entirely normal; the pelvis was ample gynecoid. Wassermann was negative. The blood type was A; Rh positive. Hemoglobin was 75 per cent.

The antepartum course was entirely without note. Blood pressures and urinalyses remained normal. Total weight gain was 26½ pounds.

At 40 weeks' gestation the patient went into spontaneous labor. After 12 hours of labor, (the last five hours and delivery carried out under continuous caudal analgesia) a living male child weighing 7 pounds, 4 ounces, was delivered by elective low forceps (DeWees), with a right mediolateral episiotomy. The placenta and membranes were expelled promptly and completely with a total estimated blood loss, at delivery, of 75 cubic centimeters. Immediate postpartum condition was good. Blood pressure was 120/82, pulse 88, respirations 24, temperature 98.4.

On the third postpartum day, her temperature rose to 101. The patient was complaining of sincipital headache. All physical findings were normal except a somewhat thickened lochia sanguinopurulenta. There was no uterine nor periuterine tenderness. She was placed in reverse Trendelenberg position and was given ergotrate 1/320 grain by mouth every four hours. Fluids were forced. For the headache, an ice cap and caffeine sodiobenzoate 7½ grains intramuscularly were given with relief. The patient appeared tired and listless. This was attributed to possible toxicity from endometritis or to the presence of some type of encephalopathy.

On the morning of the fourth postpartum day, she was extremely lethargic, complaining of headache, and had a temperature of 101.2. Urinalysis was normal. Blood chemistry revealed: urea nitrogen 9 milligrams per cent, nonprotein nitrogen 42 milligrams per cent, carbon dioxide combining power 46 volumes per cent. Blood count showed 4.3 million red cells, hemoglobin 88 per cent, 22,000 white cells with 75 per cent polymorphonuclears, 18 lymphocytes, 5 stabs, one eosinophile and one mononuclear cell. Examination by consultant neurologist showed moderate neck rigidity and a positive Kernig's sign. The spinal fluid was bloody and unclotted, and the supernatant fluid was xanthochromic. The spinal fluid pressure was 110 millimeters of water. Examination of the spinal fluid showed negative smear and culture for organisms, globulin 2 plus, total protein 250 milligrams per cent, sugar 23 milligrams per cent. The opinion of

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* From Beth Israel Hospital, Newark 8, N. J.

† Garber, M., and Maier, R. R.: American Journal of Obstetrics and Gynecology, 56:1174 (December 1948).

the neurologist was that a small congenital aneurysm had ruptured with primary subarachnoid hemorrhage.

The patient was kept at bed rest for the next 16 days. Temperature rose to 100, 100.2, and 100 on the fifth, sixth and seventh postpartum days respectively and thereafter remained normal. Treatment was symptomatic for the headache. The patient was taken home by ambulance on the twentieth postpartum day, allowed out of bed on the twenty-fourth day and thereafter made a gradual and uneventful recovery. She resumed full activity sixty days after the birth of the baby. No further evidence of discomfort or incapacity had appeared. Re-examination done ninety days after the delivery revealed normal involution of the genitalia and no neurologic residuum.

The case of subarachnoid hemorrhage here presented was of the primary type (bleeding into the subarachnoid space from a ruptured adjacent vessel). The patient showed characteristic findings: (1) meningeal irritation with headache; (2) neck rigidity; (3) positive Kernig's sign; (4) leucocytosis; (5) fever; (6) bloody spinal fluid.

It was the opinion of the consultant neurologist that the hemorrhage occurred during or immediately after labor and became clinically apparent very slowly. It was felt that the complete lack of exertion and straining during labor and delivery (which was made possible only by the management of the patient under continuous caudal analgesia) was responsible for the very moderate degree of bleeding that did take place. A more extensive amount of bleeding probably would have occurred had the patient been subjected to a longer labor with more physical effort.

Repeated lumbar punctures were not necessary since the initial tap revealed the fluid to be at normal pressure and because the patient felt better subjectively thereafter.

SUMMARY

1. A case of proved subarachnoid hemorrhage complicating pregnancy has been reported.

2. This is an example of the primary type of subarachnoid hemorrhage and was probably due to the rupture of a congenital aneurysm.

3. Continuous caudal analgesia for labor and delivery in this case probably prevented the bleeding from being catastrophic in amount.

73 Shanley Avenue

VERTIGO *

Hans Brunner, M.D., Newark, N. J.

Vertigo is a common symptom which can be discussed from many points of view. I am familiar only with the standpoint of the otologist and the following discussion is restricted to that area. To the otologist, vertigo means a specific sensation which can be elicited in almost every normal person by stimulation of the labyrinths. This type of vertigo is called labyrinthine dizziness. There are two types:[1] (1) turning dizziness, (2) tactile dizziness.

TURNING DIZZINESS

Turning dizziness is the best known and the best defined type. The afflicted person has the feeling of turning or whirling around him. Frequently he does not know what is turning around him; if asked, he usually indicates with his finger a circle-like movement. Persons who have experienced several attacks of dizziness may report that the visible objects in the space are turning around them or that they have a whirling sensation in their own bodies. Turning dizziness is not a symptom which extends with equal intensity over years as tinnitus and deafness may do; it invariably appears in attacks which usually occur without aura

* Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration. Read at the 61st Annual Session Mid-South Post Graduate Medical Assembly Memphis, Tenn., February 14, 1950.

1. Brunner, H.: Allgemeine Symptomatologie der Erkrankungen des N. vestibularis . . . Hdb.d.Neur.d.Ohres 1, 1924. 939.

and take the patient by surprise. If there is an aura it consists of a feeling of uncertainty concerning the body balance.

The attacks sets in with so powerful an intensity that consciousness may be diminished, perhaps even lost for a few seconds. It takes several hours or several days until the intensity of the dizziness subsides. A mild degree of dizziness may last over weeks and is increased by rapid movements of the head or by emotional excitement. In some cases dizziness may persist for an unusually long time apparently without showing a tendency to subside. In instances of this type, the emotional component must be considered. An attack of turning dizziness (particularly when it occurs for the first time) is a severe emotional shock. Every patient who has experienced such an attack, is terribly afraid of these spells. This is true whether he is called a "neurotic" or not. The anxiety may increase to such a degree that he finally does not know whether he remembers the feeling of dizziness or actually feels it. In genuine neurotics, a true anxiety neurosis may become manifest. In these cases, we may ask: is there an involvement of the labyrinth in addition to the neurosis or is the entire symptom complex of neurotic origin? To answer this, the patient must be examined for a spontaneous nystagmus. *If there is a spontaneous nystagmus the diagnosis of organic involvement of the labyrinth must be made regardless of the intensity of the neurotic symptoms.* If there is no spontaneous nystagmus a subclinical stimulation should be applied to elicit an eventually latent nystagmus. In this respect the following simple method is suggested: The examiner takes the head of the patient with both his hands and bends it rapidly backwards. If there is a slight involvement of the labyrinth, a nystagmus will become manifest. Unfortunately it may not be possible to perform this test during the acute spell because patients know that movements of the head make them dizzy and, thus, they do not allow their head to be moved. Nevertheless, the patient usually can be persuaded to stoop forward or to turn the head slowly to the right or to the left. In many instances, this may be sufficient to elicit a nystagmus.

Turning dizziness is usually associated with nausea and with muscular reactions. Nausea occurs in the majority of adults and it is the symptom which the patient most dreads inasmuch as it is associated with other symptoms of the sympathetic nervous system such as pallor, perspiration, acceleration of pulse and respiration and eventually, increase of blood pressure. However, it does not occur invariably. It may be absent—for unknown reason—in some adults and it is usually absent in children. In the latter a mild degree of dizziness is associated with a feeling of pleasure; thus it indicates a severe degree of vertigo when a child makes a complaint of dizziness and when the dizziness is associated with nausea or projectile vomiting.

Among the muscular reactions the nystagmus is of greatest importance. It is a fair conclusion that turning dizziness, even of mild degree, is invariably associated with nystagmus. In slight, fleeting attacks the nystagmus may be absent. Nevertheless, it is important to search for nystagmus in every patient who complains of turning dizziness. Nystagmus of labyrinthine origin is invarably a "jerky" nystagmus. It consists of a slow and rapid movement of the eyes. The slow component can be identified infrequently; the rapid movement is conspicuous and is easily noticed. In fact it is usually the rapid movement of eyes only which is noticed by the examiner and for this reason the direction of the nystagmus is called after the direction of the rapid movement of the eyes. For example, a nystagmus to the right means that the rapid movement is to the right.

The examination for spontaneous labyrinthine nystagmus is simple. The head of the patient is bent slightly backward, approximately 30 degrees, and the upper eyelid is gently —never with force—raised. The patient is told to look at the finger of the examiner which is held at a distance of about three feet. It is incorrect to put the finger closer to the patient's eyes because then the patient converges his eyes and thus suppresses the nystagmus. The examiner moves his finger slowly to the right, to the left, upward and observes the eyes for a nystagmus which fre-

quently appears only in the end-positions of the eyes.

Turning dizziness is a valuable symptom. Dizzines *per se* does not allow more clinical conclusions than, for example, abdominal pain. The patient must be encouraged to furnish exact data concerning the sensation which he calls "dizziness" without being influenced by leading questions. No patient who actually experienced turning dizziness will fail to indicate that something has turned around him, thus establishing the diagnosis, not of dizziness in general, but of turning dizziness.

TACTILE DIZZINESS

The tactile type of labyrinthine dizziness is less clearly defined and from a practical viewpoint, less important. Two subdivisions are encountered in practice: (1) Errors in the tactile perception of space, and (2) lateropulsion. Errors in the tactile perception of space indicate that the patient receives false information from the sense organs concerning the surrounding space. For example, the patient lies in reclined horizontal position in the bed. If he closes the eyes, he has the feeling that the footend of the bed is higher than the other end. Or he walks on a flat street and has the feeling of walking uphill; or he touches, the eyes closed, a perpendicular rod and has the feeling that the rod is inclined to one side. All of these phenomena are errors in the tactile perception of space. The ordinary patient, of course, does not analyze these sensations and usually summarizes all of these errors by saying that he has a feeling like being drunk. This type of sensation is common and must be evaluated as a form of labyrinthine dizziness because it can be elicited in normal persons by galvanic stimulation of the vestibular nerve. In contrast to turning dizziness, it is not always associated with spontaneous nystagmus.

Lateropulsion consists of the feeling of being pushed or pulled to one side either to the right or to the left, never straight forward or backward. The attack may be so powerful as to cause the patient to fall. He may even hurt himself. There is no loss of consciousness during the attack.

The finding of labyrinthine dizziness of any type indicates that there is an involvement of the labyrinth, the vestibular nerve or the central pathways of the vestibular nerve. The lesion is not necessarily structural, since vasomotor involvement in this area causes the same type of dizziness. An exception is lateropulsion which seems to occur only in nonpurulent diseases of the brainstem, as multiple sclerosis, vascular lesions, and encephalitis. Lateropulsion does not occur in purulent diseases of the brain, such as brain abscess.

TREATMENT

Labyrinthine dizziness is not a disease; it is, rather, a symptom of disease. Treatment should not be instituted until the basic diagnosis is established. It is possible that successful treatment of vertigo may mask a serious disease (such as brain tumor) or a latent infection of the inner ear. For this reason, in all who complain of labyrinthine dizziness, otologic and neurologic examinations are necessary. If there is no need of a specific otologic or neurologic treatment, various procedures are available to relieve vertigo.

In the very first stage of an attack, rest is of primary importance. The room should be darkened, and no visitors should be admitted. The patient, lying in bed, should assume a position which diminishes the intensity of nystagmus and the dizziness. If there is, for instance, a nystagmus to the right, the patient should lie on his right side. In this position, the eyes deviate to the left. This movement of eyes exerts an inhibiting effect upon a nystagmus to the right and, thus, on the dizziness. A mild laxative should be given unless there is too much nausea, in which case, of course, no drug can be given by mouth.

The usual sedatives and narcotics are of little value because they do not exert any influence upon the central irritation of the vagus and sympathetic nerves. Only in some cases they may be given to calm the emotional excitement of the patient. A specific treatment is, theoretically not necessary because the attacks resolve spontaneously. Specific treatment aims at a shortening of the duration of the attacks and at preventing further attacks. For this purpose intravenous injection of his-

tamine was suggested. I have had experience with "Vasano" and "Nautisan". "Vasano" is a combination of atropin and scopolamine. Atropin alone diminishes the nausea to a moderate degree if given by subcutaneous injection but is practically without effect if given by mouth. This indicates that the nausea is not caused just by irritation of the peripheral endings of the vagus. In that case the oral administration of atropin would be effective. However, if atropin is combined with scopolamine, the latter acts synergistically with atropin upon the peripheral endings of the vagus and has, in addition, a sedative effect upon the centers of the vagus. Two tablets of "Vasano", 0.5 milligrams each, may be given. Maximum dose is four tablets in 24 hours. It can be administered as a rectal suppository or by subcutaneous injection. The vegetative symptoms (perspiration, acceleration of pulse and respiration) fail to appear in normals if two tablets of "Vasano" are administered two hours prior to examination in the turning chair. There is no influence upon the vertigo, but the vertigo is not associated with fear or nausea. A side effect is slight dryness in the mouth and throat.

"Nautisan" contains chloretone and caffeine. It is frequently administered as a suppository. This preparation produces a certain degree of drowsiness within an hour after administration. In normals who have taken two pills of "Nautisan" the vertigo is considerably diminished after the turning test. The vegetative symptoms are likewise diminished but are not entirely eliminated. "Nautisan" is much used in Europe.

For patients who suffer from a mild but chronic dizziness, the treatment depends on the presence or absence of spontaneous nystagmus. If a strong nystagmus is constantly present, the patient must be closely watched for organic brain disease. If no nystagmus is discovered, psychotherapy is of primary importance. These patients are frequently afraid of another attack or of a brain tumor. They should be reassured and sedated. In addition, medical treatment should be instituted. Frequently administration of vitamins, iron and tonics is of great value in improving the general physical status. In the past various drugs were used which, unfortunately are more or less forgotten. Useful perscriptions are:

℞	Extract of belladonna	0.4
	Sodium iodide	5.0
	Sodium bromide	9.0
	Distilled water to	200.0

Sign: Tablespoonful three times a day (after meals).

℞	Potassium nitrite	24.0
	Sodium bicarbonate	24.0
	Sodium nitrite	3.0
	Distilled water to	300.0

Sign: A tablespoonful in glass of water; take slowly during the half hour before breakfast.

Nicotinic acid and pyridoxine (50 milligrams) two tablets a day have been suggested, but I have little experience with this combination. Histamine sensitive patients may, perhaps, be desensitized with gradually increased doses of histamine subcutaneously. I have also used "Dramamine" but do not find it helpful.

Another approach has been suggested by applying dietary measures. One group of otologists advocates restriction of water intake while another suggests restriction of sodium chloride. While successful in some cases, treatment directed along these lines has in general not been encouraging. Restriction of water and salt is difficult to enforce unless the patient is hospitalized.

A few patients do not respond to any treatment of this type. In these cases, a destruction of the labyrinth should be considered, provided that hearing has already been severely damaged by the disease. This type of treatment falls strictly into the realm of the otologist.

417 Mt. Prospect Avenue

OCCUPATIONAL DERMATOSES

Seymour L. Hanfling, M.D., East Orange, N. J.

About 3 per cent of all workmen's compensation claims represent occupational dermatoses. The loss is estimated at about $100,000,000 per year. The proportion of occupational dermatoses to all dermatoses varies according to the ratio of industrial workers to the total population, the type of industry, and the criteria used in arriving at a diagnosis. This has been reported at from 2 to 20 per cent. Several states report the average time loss per year for occupational dermatoses to be about ten weeks, the average compensation paid about $100, and the average medical care about $90.

The skin's defense mechanism against external irritants consists of the cornified cells of the outermost layer and the secretions of the glands. These cornified cells are insoluble in water, alcohol and even fairly strong acids but are dissolved by alkalis and sulfides. The most vulnerable portions of the skin are the duct and hair follicle openings through which certain compounds may enter. Any thinning of the horny layer also acts as a portal of entry for external irritants.

Race influences susceptibility. The Negro is less susceptible to irritation; the Mongolian race is more susceptible probably because of their greater and lesser oil secretion respectively.

As types of skin vary, so does their susceptibility. The blonde is more sensitive to irritation and friction, the brunette, more sensitive to the oil dermatosis, particularly those with considerable hair on exposed areas. The thin skin of the body (inner surfaces of the arms, eyelids, et cetera) are more susceptible. The palms, although more exposed, are less frequently involved. This can be explained by the habit people have of washing their hands frequently thereby removing noxious substances before they do much harm. In addition, the skin of the palm is much thicker than that on other areas, thereby offering additional protection.

Women, due to the greater dryness of their thinner skins, are more sensitive to external irritants, although their better hygiene and earlier care help compensate for this.

The chemical causes of occupational dermatoses include primary irritants and cutaneous sensitizers. A *primary irritant* is one which will cause a dermatitis on first exposure by direct action on the normal skin at the site of contact if allowed to act in adequate strength for sufficient time.[1] There is a chemical or physical effect on the portion of the skin contacted which results in inflammation, vesiculation, or even destruction of that area. The intensity of effect varies directly as the concentration of the irritant and the duration of the contact. A *sensitizer* does not necessarily cause a demonstrable skin change on first contact but after six or seven days may cause changes so that further contact on that (or other) locations will cause a dermatitis. Most occupational dermatoses are caused by alkalis, acids, corrosive salts, solvents, and dehydrators. These substances actually produce chemical changes in the skin. The alkalis in adequate strength or frequency of contact dissolve the outer keratin layer. Acids are less destructive but produce similar results. Corrosive salts denature the proteins of the cells to form a coagulum. The solvents dissolve the skin oil secretions, thereby removing this protective coat. This results in dry thickening of the skin particularly during the cold winter months when the oil secretion is at a minimum and its need is greatest. The dehydrators upset the osmotic balance of the cells. Only a small proportion are due to allergy. In a compilation of 10,000 cases from state compensation boards the ratio was four of primary irritations to one of allergy.

Allergic dermatitis usually develops in a new worker and occurs seven to ten days after the first exposure. Fortunately, if the worker can continue at his work, the dermatitis sometimes will clear up after a period of time. This has been called "becoming hardened".[2] Apparently, a gradual desensitization takes place due to small continued exposures which act like immunization injections on the hay-fever sufferer. This immunity is present for only a limited exposure. If the worker stops his

1. Schwartz, L. *et al.*: "Occupational Diseases of the Skin". ed. 2. Philadelphia, Lea and Febiger, 1947. (Page 35)

2. Sulzberger, Marion: "Dermatologic Allergy". Baltimore, Charles C. Thomas, 1940. (Page 55)

contact, the immunity is gradually lost. The worker who develops a sensitivity after years of exposure seldom becomes "hardened". Workers who develop severe reactions requiring lay-offs, rarely develop an immunity ("become hardened") and therefore must be transferred to other occupations. Attempts at "hardening" by injecting minute but increasing quantities of the sensitizing substances are successful in only occasional cases.

The actual causes of occupational dermatitis are:

1. *Mechanical agents* such as friction, pressure, and trauma. These result in calluses, lacerations, and abrasions. Wounds readily become infected with bacteria or fungi. They also become sites for new lesions in certain generalized skin diseases as psoriasis and lichen planus (Köbner's phenomenon).[3]

2. *Physical agents* such as heat, cold, water, sunlight, and radiation. Heat causes perspiration and softening of the horny layers which (along with friction) produces intertrigo of opposing surfaces, and heat rashes. Thus, by decreasing the skin resistance, there is greater reactivity to weaker primary irritants which would not ordinarily affect it.

3. *Chemicals* are the chief causes of eruptions in industry. Primary irritants or sensitizers are used in practically all industries. Lists of these primary irritants and sensitizers may be found in texts[4] on industrial dermatology.

4. *Plant poisons* such as the Rhus family (which includes poison ivy, oak, and sumac) cause dermatoses due to sensitization.

5. *Biologic agents* such as bacteria, fungi, and parasites make up another group. They more frequently complicate than cause occupational dermatoses.

The history is important in reaching a diagnosis. Onset must be after 5, 6 or 7 days on the job and within 7 days after leaving the work. The presence of other workers similarly employed and exhibiting the same eruption naturally strengthens the possibility of an occupational dermatitis. Knowledge of the working processes by the physician enables him to know to what irritants or sensitizers the patient is exposed.

Site of the eruption is also important. A complete examination is necessary to determine the extent of the eruption and sometimes to find a pre-existing systemic skin disease. Occupational dermatoses usually begin on the exposed surfaces or at points of maximum friction.

Some occupational dermatoses are characteristic. These include paronychia in canners and dishwashers, acneform lesions in workers exposed to chlorinated naphthalenes, et cetera, hair follicle infections from oils, acne and keratotic lesions from tars, chapping first and later dry fissured eczemas from hydroscopic chemicals which remove water from the skin or from solvents which remove the protective oils. However, most cases are contact dermatoses and present erythema, papules, vesicles, oozing, and crusting regardless of the specific cause which might be industrial or domestic in origin.

The patch test is the most effective rapid means of determining the presence of a sensitivity. It consists of applying a minute amount of the suspected substance to a ¼ inch square of gauze and of placing it on the skin, usually of the back. It is covered with an oval piece of adhesive in the center of which is a piece of cellophane.[5] The areas are inspected within 48 hours. Care should be taken that the substance is not a primary irritant since these almost always cause positive reactions. The presence or absence of a mild reaction is not absolutely conclusive of the presence or absence of the causative substance. During the acute stage, the skin may develop a multi-sensitivity to many substances to which it is normally nonreactive.[7] The conditions involved in patch testing rarely accurately duplicate those in the patient's actual environment and false negatives may result. On the other hand, we have all seen weakly positive patch tests after 48 hours, where we are sure the dermatitis could not have resulted from this contactant. The patch tests are interpreted as follows:

3. Ormsby, O., and Montgomery, H.: "Diseases of the Skin". ed. 7. Philadelphia, Lea and Febiger, 1948. (Page 306)
4. Schwartz, L. *op. cit.*: (See citation 1.) Pages 42 and 46.
5. Schwartz, L.: *Clinics*, 5:436 (1946).
6. Sulzberger, Marion: *op. cit.* (See citation 2.) Page 98.
7. Hanfling, Seymour L.: Journal of The Medical Society of New Jersey, 46:568 (1949).

One plus: Erythema.
Two plus: Erythema, papules and edema.
Three plus: All above plus shall blisters.
Four plus: Bullae formation, i.e., one large blister of patch test area.

Basic principles of therapy are: first, removal of the patient from possible contact with the causative agent by change of work, time off from work, or (whenever possible) by complete protection of the parts involved. This involves the use of protective ointments and protective clothing such as rubber gloves and aprons. And second, by use of only the mildest lotions and ointments. In the acute stage, cold compresses of weak solutions or luke warm colloid baths give the best results.

The problem of differentiation of most skin diseases from contact dermatoses is not difficult for the experienced observer. The major difficulty is presented by a non-occupational disease masked by a self-produced contact dermatitis from home treatment. Here the area of greatest involvement is the original area treated. The secondary areas involved are most commonly due to spread of the therapeutic agent via the hands to the face with involvement of both. Only complete patch testing plus careful evaluation of all facts can lead to a correct diagnosis in these cases. There is also the problem of differentiating a contact dermatitis from *nummular eczema* (also called orbicular eczema or exudative neurodermatitis). This has been reported[6] as a frequent cause of confusion. Although often clinically similar, it seems to be a separate entity since it has been impossible to demonstrate the causal role of any known eczematogenous allergen. Its cause is unknown, but is believed to be some form of skin allergy of internal origin such as a focus of infection or drug ingestion.

Another group of dermatoses causing much confusion in differential diagnosis are the secondary eruptions or "ids" as they are usually called. These are internal sensitivity reactions to fungi, drugs, or toxic substances produced in an area of dermatitis. Clinically the eruption is indistinguishable from a contact dermatitis from external causes. As a rule though, these present deeper vesiculation localized to the fingers and palm and with less erythema and pruritus.

SUMMARY

1. Occupational dermatoses make up 3 per cent of all compensation cases at a cost estimated at about $100,000,000 per year.
2. The factors affecting resistance and susceptibility are presented.
3. Primary irritants and cutaneous sensitizers are defined and discussed.
4. "Hardening" of the skin takes place occasionally. Desensitization with ascending doses is rarely successful.
5. The main causes of occupational dermatitis are: (a) Mechanical agents, (b) Physical agents, (c) Chemical agents, (d) Plant poisons, and (e) Biologic agents.
6. The history, physical examination, and patch test reactions all combine to help make the diagnosis.
7. Differential diagnosis is mentioned briefly.

115 South Munn Avenue

18th CENTURY MEDICINE IN NEW JERSEY

From the minutes of The Medical Society of New Jersey, meeting of Nov. 1, 1785: "Jacob Probasco, a lad of 17 years, with a tumor of the forearm was brought before the Society for examination and advice. After due deliberation, the gentlemen of the Society were of the opinion that whether it was an encysted tumor or an aneurysm, incision ought to be made with a view, if possible, to save the limb. And at the time of making the incision into the tumor, every preparation for amputation should be made in case it should be found necessary." (Page 46 of the 1785 *Transactions of The Medical Society of New Jersey.)*

CARBON MONOXIDE DETECTION IN ROUTINE BLOOD EXAMINATIONS

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An easy opportunity is available to detect carbon monoxide poisoning when a blood sample is taken for any purpose. Blood examinations for highly specialized purposes are usually limited to hospital patients. However, in office practice, many patients have a blood sample taken for a routine Wassermann, hemoglobin, blood counts and/or blood sugar tests. The change which is present (and is readily noted in the blood) is the cherry red color present when carbon monoxide poisoning has occurred. Troja[1] in 1778 gave one of the first detailed descriptions of carbon monoxide poisoning in which he noted this cherry red color. Bernard[2] in 1857 found that this color is caused by a new pigment resulting from the combination of carbon monoxide with hemoglobin.

Toxic symptoms usually begin when the concentration of carbon monoxide in the blood (as carbon monoxide hemoglobin) rises above twenty per cent. This represents an absorption from a concentration of about 250 parts (or more) per million in air of carbon monoxide.[3] The maximum permitted amount in industry is 100 parts per million. Gross changes in the color of the blood can occur when the concentration of carbon monoxide in the blood is well below toxicity producing levels.

For this reason, simple examination of the color of the blood, whenever this opportunity occurs in practice, offers an excellent indication of the amount of exposure of patients to carbon monoxide.

The simplest laboratory test available is the Hoppe-Seyler Test.[4] It requires no chemical except sodium hydroxide. To three cubic centimeters of water in a test tube add three to five drops of the blood and one drop of five per cent solution of sodium hydroxide. Mix and let stand for one hour.

Normal blood gives a greenish-brown color; blood that contains over twenty per cent of saturation of carbon monoxide is pinkish. Always run a control.

An example of such a color change in the blood occurred in a patient under my care. This blond male, age 44, was under treatment for an eczema hemostaticum. A routine Wassermann test was brough to my attention because of the cherry red color of the blood which was quite decided. The Hoppe-Seyler Test was very positive. The patient, a tavernkeeper, had no toxic subjective symptoms, felt well and was in good spirits. A slight definite erythema of the entire skin surface was present. This is not uncommon in carbon monoxide poisoning. Papular dermatitis, localized edema of the skin, purpuric changes and blisters may also occur. Rabinowitz[5] considered the very early appearance of decubitus ulcers as pathognomonic of carbon monoxide poisoning. A check of the environment of this patient revealed an oil furnace with an inefficient timing device which permitted large amounts of oil to accumulate in the furnace before firing started. This in turn accounted for the incomplete combustion of the oil and the production of dangerous amounts of carbon monoxide. On correcting this the cherry red color of the blood rapidly returned to normal.

The exposure to dangerous amounts of carbon monoxide is much more common in the winter when poor ventilation due to tightly closed rooms accentuates the possibility of serious accidents. Any heating device, especially of coal, gas and oil may produce carbon monoxide poisoning. Revitch[6] states that a fair number of patients who have not suffered acute effects from low-grade carbon monoxide poisoning may years later develop neurologic changes due to basal ganglia hemorrhages which occurred at the time of exposure. Inhalation of car exhaust fumes in a closed garage is rapidly fatal.

Simple gross observation of blood specimens may provide a helpful clue for the detection of carbon monoxide poisoning. A simple laboratory confirmatory test is available. Unexplained symptoms in any patient justify this procedure.

Footnotes appear in the author's reprints.

7 Watchung Avenue

MANAGEMENT OF HYPERTHYROIDISM *

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Until a few years ago we thought that, with few exceptions, treatment of hyperthyroidism was well standardized: subtotal thyroidectomy, pole ligations and stage operations,—with an operative mortality below one per cent.

Then along came antithyroid drugs and radio-active iodine. With these, came the necessity to revise, or at least to reconsider our previous position. This has all happened within the last six years.

We still have three methods of approach to hyperthyroidism:

1. Surgery
2. Medical, with propyl thiouracil or with radioactive iodine.
3. A combination of both methods.

By the use of iodine preparations the surgical mortality was less than one per cent for hyperthyroidism of the "smooth" type and 1½ to 3 per cent for the nodular type. But this was accomplished only by resorting to polar ligations and stage resections of the gland. Even then, we were faced with severe postoperative reactions, often requiring complicated treatment over a period of 24 to 72 hours. Too often it necessitated a hurried operation. The scar on the neck is obviously of secondary importance.

Since the introduction of thiourea preparations, practically all cases are brought to the operating table with normal metabolic and pulse rate. Stage operations are almost unknown and the procedure does not have to be hurried. High pulse rates and high changes in the blood pressure during operation have almost been eliminated. In other words, with the use of antithyroid drugs, it is now possible to control thyrotoxicosis almost completely. Thus, the operation can be performed during the "euthyroid" stage, with a reduction in operative mortality almost to zero.

Iodine still plays a significant role in treating and preparing patients for operation. The factors here are:

1. Iodine is swallowed and absorbed from the small intestine as sodium or potassium iodide.
2. Almost all the absorbed iodine is taken to the thyroid gland (10,000 times more in the thyroid gland than in the blood serum).
3. The inorganic iodine (sodium and potassium iodide) in the gland combines with tyrosine to make diiodotyrosine.
4. Diiodotyrosine combines with the albumin fraction, globulin, by oxidation, which makes organic thyroglobin, and as such is stored as colloid.

Liberation of iodine from thyroid acinus supposedly is accomplished by a proteolytic enzyme converting thyroglobin into thyroxin, which is liberated upon call by the pituitary thyrotropic hormone. Thyroxin is regarded as the thyroid hormone. Just how it gets out of the acinus into the blood stream has not yet been acceptably solved. There is only one layer of epithelial cells lining the thyroid acinus. Some think these cells are bipolar, allowing the inorganic iodine to enter and the organic iodine to leave through the metabolic physiology of this same cell. This, however, is conjectural.

In primary hyperthyroidism this orderly process is disturbed. The thyroid acinus is stimulated by excessive pituitary thyrotropic hormone, causing reduction in the iodine in the acinus, increase in the blood iodine, decrease in cholesterol and hypertrophy of the acini which results in enlargement of the gland.

When iodine is then supplied therapeutically the iodine in the acini increases, blood iodine remains increased, cholesterol becomes more nearly normal and the gland usually recedes in size and goes into remission. However, the pituitary thyrotropic hormone continues to be above normal and prevents a permanent remission.

When propyl thiouracil is therapeutically administered, iodine in the acini decreases, blood iodine decreases towards normal because conversion of inorganic iodine into organic iodine is blocked. The size of the gland usually remains unchanged because excessive thyrotropic hormone stimulation remains. It appears that uptake of iodine is therefore halted and probably absorption from the intestine is inter-

* Read before the staff of the Shore Memorial Hospital. Dr. Johnson is chief in surgery, Atlantic City Hospital and Shore Memorial Hospital, Somers Point, N. J.

fered with as there is no increase in the blood iodine.

When both propyl thiouracil and iodine are given there is a moderate increase of acinar iodine, and an increase in blood iodine. The gland recedes in size as involution begins, but remission does not occur as the acini only becomes nearer normal.

When propyl thiouracil is discontinued and iodine continued, involution occurs. The gland becomes smaller, colloid increases in the acini (increases in acinar iodine), i. e. increased amount of colloid space as cells become flat instead of tall.

If the previous paragraphs are accepted as the metabolic process occurring in hyperfunction of the thyroid I think we can approach more confidently the management of hyperthyroidism. First, we can definitely say that:

1. Propyl thiouracil is never indicated for goiter unless associated with hyperthyroidism.

An increased metabolic rate alone may be misleading. Many drugs, diseases and psychosomatic conditions may increase the metabolic rate. A rise in basal metabolism may occur, for example, in fever of any origin, in leukemia, in heart disease, in polycythemia, in intestinal obstruction, in obesity, in asthma and in ascites from any cause. Such drugs as epinephrine, dinitrophenol, amphetamine, and—of course—the thyroid extracts, may whip up the metabolic rate. Actually any condition causing increased heat production may manifest itself by a stepped-up metabolic rate. This occurs in emotional, intellectual, digestive and muscular activities of various sorts.

It is naive to suppose the metabolic rate is a simple product of thyroid activity. Actually, metabolism is the sum total of *all* the chemical, physical, and electrical reactions taking place in the body at a given moment.

2. Propyl thiouracil does not usually cause hypertrophy or enlargement of the gland to disappear.

3. It has no effect on adenomas other than to control hyperfunction.

4. There may be cases in which the hyperthyroid symptoms can be permanently controlled and involution maintained by the use of propyl thiouracil plus iodine; but not by the use of the thiouracil alone.

1. Lahey, Frank H.: Personal conversation.
2. Bartels, Elmer: American Journal of Medicine, 5:48 (July 1948).
3. Crile, George, Jr.: Journal of the Canadian Medical Association, 57:359 (October 1947).

We must differentiate between the cases that can be treated medically (by propyl thiouracil or radio-active iodine) and those that must (or might) become candidates for surgery. It is easier to list those that should, with our present knowledge, be accepted *prima facia* for surgery. They are:

1. Hyperthyroidism with moderate to considerable gland hypertrophy.
2. For non-toxic enlargement (Cosmetic reasons).
3. For nodular goiter, fetal and nodular adenomas may be carcinomatous or pre-cancerous.
4. When recurrence of toxicity occurs shortly after propyl thiouracil is discontinued.
5. Cases resistant to propyl thiouracil and I^{131} therapy.

Our present experience may justify an attempt at definitive medical therapy for:—

1. Hyperthyroid state plus increased basal metabolic rate without hypertrophy of the thyroid gland.
2. For very small hypertrophy of the gland with moderate hyperthyroidism.
3. Hyperthyroid with short life expectancy because of age or associated disease.
4. Persistent postoperative hyperthyroidism.
5. Recurrent hyperthyroidism.
6. During pregnancy.

Dr. Lahey[1] has said that every case of hyperthyroidism when given propyl thiouracil long enough and in big enough doses can be brought to the state of "euthyroidism". While there are exceptions to every rule, on the whole, this statement is almost correct. One of my patients became progressively more toxic over a period of six weeks under 300 milligrams of thiouracil daily. Of course this may not have been enough. Another patient had precordial pain every time propyl thiouracil was given. Electrocardiogram was negative.

Bartels[2] reports 13 reactions in 672 patients at Lahey Clinic, all but 3 involving the blood stream. Crile[3] reports 218 cases from the Cleveland Clinic with one death questionably due to the drug, one very serious case of exfoliative dermatitis with eventual recovery and 3 per cent side reactions: granulocytopenia, urticaria, arthralgia, nausea, sessation of numbness. Therefore its use must still be carefully supervised. Is propyl thiouracil a definitive treatment? *The day has not yet arrived to speak of medical cure.* Insufficient time has elapsed to evaluate this.

For medical therapy the usual dose is 300 milligrams daily until *apparent* remission has occurred. Dosage is then reduced to 50 to 100 milligrams daily as a maintenance dose. Some authors have used up to 600 and even 800 milligrams per day.

It is not enough to relieve the symptoms of hyperthyroidism; the hypertrophy of the gland must also be eliminated, before one is justified in speaking of medical cure. The argument that the thyroid gland is not the primary site of the disease in Grave's Disease is well put and generally agreed upon; but until some more satisfactory method is found, we must continue to utilize our present regime, which in the vast majority of cases means surgery as the ultimate definitive weapon.

Most observers report that the hypertrophy of the gland remains unchanged; some, that the gland becomes smaller and may even become impalpable. I have seen postoperative hypertrophy disappear, but this was concommitant with correction of disturbed home difficulties. The overall picture is that control of symptoms may be anticipated, but that reduction of the hypertrophy should not be expected.

For pre-operative preparation the usual routine is:—

(A) 300 milligrams of propyl thiouracil alone daily; 100 milligrams three times a day for two weeks (average).
(B) Then add Lugol's solution, 10 minims, three times a day for two weeks.
(C) Stop the propyl thiouracil and continue the Lugol's solution alone for two weeks.

Larger doses of propyl thiouracil and over a longer period of time may be required.

(D) Phenobarbital ½ grain four times a day throughout the regime.

RADIO-ACTIVE THERAPY

Radio-active iodine has the usual properties of stable iodine, but has the added property of emitting radiations. The radiations have the same biologic effects as radiations emitted by radium or x-ray machines. Because of the selective localization of the substance in the thyroid gland, it can be administered by mouth to produce internal radiation of the thyroid tissue and thus be used as a therapeutic and diagnostic agent. It is made in the atomic pile at Oak Ridge, by the Atomic Energy Commission and shipped by air at a cost of about $1.50 per milli-curie. It emits beta particles and gamma rays. Its half life is eight days. At the end of eight days, half of the stock will have disintegrated and in eight more days half of what is left will have disintegrated and at the end of fifty-three days 99 per cent of the original stock will have disintegrated. This, therefore, makes it necessary for a physicist to measure the dosage at the time therapy is instituted.

Radio-active iodine must be handled with care. Precautions similar to those used by radium therapists must be observed. Urine from patients who have been given radio-active iodine may contain dangerous quantities of the isotope and its disposal is a difficult problem, considering the number of untrained hospital personnel who may misplace it, spill it or contaminate a room with radio-active material.

Radio-iodine is given by mouth in solution which is water-clear and almost tasteless. The patient's stomach should be empty. He may eat an hour later as by that time 90 per cent of the dose has been absorbed by the gastrointestinal tract. As soon as radio-active iodine enters the blood stream, the thyroid gland begins collecting it and the kidneys begin excreting it. Eighty to ninety per cent of the radio-iodine is taken to the thyroid gland and at the end of 48 hours 20 to 30 per cent is collected by it, 10 per cent distributed elsewhere in the body and the remaining 60 to 70 per cent is excreted in the urine. This naturally raises the question of possible damage to the renal epithelium. It should not be used in the therapy of hyperthyroidism within six weeks of iodine administration as the capacity of the thyroid for uptake of iodine is reduced proportionately to the amount of colloid (iodine-containing) present.

In hyperthyroidism, the avidity of the thyroid for iodine is great. While it varies in different individuals, about 90 per cent of the dose is taken immediately to the gland and its rate of excretion is rather proportional to the hypermetabolism. Rate of uptake, as measured by a Geiger counter, is proportional to the thyroid hypermetabolism. If the existing hyperme-

tabolism (B. M. R.) is not due to thyroid hyperfunction the uptake will be normal or may even be below normal. Thus hyperthyroidism and other processes causing increased metabolism may be differentiated. Radio-iodine uptake is measured easily with the Geiger counter by anyone familiar with its use.

Radio-iodine is unavailable in most parts of the country. The Atomic Energy Commission requires that the institution to be supplied must have an "Isotope Committee" consisting of medical clinicians and a physicist; and that it have a room properly equipped to handle and store the isotope. These requirements are out of the question for all but a few medical institutions. Therefore it will take a long time to secure enough clinical experience to evaluate the position of radio-iodine in the therapy of goiter. The establishment of more centers will facilitate the appraisal of radio-iodine therapy. Existing facilities might be expanded so that the "bottle neck" could be removed. The physicist is the "bottle neck". Proper storage, handling and disposal could be arranged by most approved hospitals; an "Isotope Committee" could be arranged in most approved hospitals. Until this is done, large scale evaluation will not be possible. The few medical institutions properly equipped with a physicist should not monopolize his services any more than they should monopolize radon suppliers. The latter can calculate the milli-curie hours of radon emanation to be sent to any part of the country for use at a specific hour and day of the year. The same arrangement probably could be made for radio-active elements.

X-rays and radium have always been controversial as a definitive method of controlling hyperthyroidism. Latterly they have been almost wholly abandoned. Radium and x-ray, however, have been a great help in preparing some patients for surgery. Its effect on the overlying skin, fascia and muscles—telangiectasis, discoloration and adhesions— has prevented its use in sufficiently destructive doses on the gland acini. Radio-active iodine eliminates these objections and may therefore replace x-ray and radium therapy.

Carcinoma of the thyroid has been proposed as the best indication for radio-active iodine therapy. But results have been disappointing. Radio-active material is carried by iodine and carcinoma usually destroys and replaces the thyroid glandular tissue (resulting in lack of avidity of the thyroid for iodine), so that there is no way for the radio-activity to be taken to the thyroid gland. The futility of this method of treatment of thyroid carcinoma can, therefore, be well understood. Of course, there are some cases of carcinoma (adenocarcinoma within a fetal adenoma) that do produce thyroid secretion in excess that might react favorably to radio-iodine in preparing the patient for surgery but it has not been demonstrated in any case reports available to me, that cure has been obtained. In dealing with carcinoma, one becomes desperate; yet it is here that utmost precaution must be exercised. Once the radio-iodine is swallowed it must be utilized and eliminated. If not utilized, too much must be eliminated and the danger to the kidney, and other organs, is necessarily increased.

CONCLUSION

1. Surgical removal of nontoxic and toxic adenomas is the treatment of choice. Surgical resection for hyperthyroidism is now such a safe procedure that postoperative mortality can almost be forgotten. Complications such as unilateral or bilateral cord paralysis and recurrent hyperthyroidism and hypoparathyroidism will be reduced because of better surgical working conditions at the time of operation. *Surgery is still the keystone of cure.*

2. Propyl thiouracil may be used as a definitive cure for hyperthyroidism in a small number of cases without palpable thyroid enlargement or with very small hypertrophy. It can help in the management of hyperthyroidism associated wih pregnancy, persistent and recurrent hyperthyroidism and for cases with short life expectancy due to age or other incurable organic disease.

3. Radio-iodine is available to only a small proportion of cases. Indications for its use are not at all clear.

101 South Indiana Avenue

LEFT HEPATO-JEJUNOSTOMY FOR BILIARY OBSTRUCTION

WITH CASE REPORT

Robert L. Lewis, Jr., M.D., Elizabeth, N. J.

This is a case report and no attempt is made to review the literature on the subject. I am indebted to Dr. Edgar Burke, Chief Surgeon of the Jersey City Medical Center, for the privilege of operating on this patient.

A 45 year old, white male, was admitted to the Jersey City Medical Center on October 19, 1949. He had had a cholecystectomy and drainage of the common duct at another hospital, on May 10, 1949. Postoperative course had been uneventful and he had returned to his usual occupation. About October 1, 1949, he developed a painless jaundice, which had rapidly progressed in severity. He had no other symptoms except that his urine was getting darker and his stools lighter in color since onset of his jaundice.

He was a thin white, deeply jaundiced male. There was a well healed, upper right rectus scar. Liver was palpable one finger below the costal margin. The stool was clay colored and the urine very dark. No other significant physical findings were noted.

Laboratory examinations on admission showed urine positive for bile and urobilinogen. Stool was negative for bile. Red cell count was 4,180,000. Leucocytes numbered 7200. Blood sugar was 140. Nonprotein nitrogen was 28. Cephalin flocculation test was positive. Serum bilirubin was 32. Serum protein was 6.2. X-ray spot film of the right upper quadrant showed no evidence of radio-opaque biliary calculi.

Clinical impression was common duct obstruction due to stricture or retained calculi.

Operation: On October 26, I explored the abdomen through an upper right rectus incision, with the following significant findings. There was a stenosis of the upper common and the right and left hepatic ducts, causing complete obstruction of the biliary tract. The distal portion of the common duct was thickened but did contain a small lumen through which a fine probe could be passed into the duodenum. The right and left main branches of the hepatic duct were dissected free from the liver substance as far as possible. They were found to be involved in the stenosing process beyond this point. Attempts were made to pass a fine needle up the stenosed ducts (in the hope of hitting a pool of bile in the dilated duct above) but these were unsuccessful. A T-tube was placed in the common duct and the abdomen closed in layers around the tube. Further operative procedure was not considered advisable at this time because of the lack of any marked increase in the size of the liver. This would indicate that, although complete obstruction was present, very little dilatation of the intra-hepatic bile ducts had occurred.

Following this operation the jaundice deepened. Serum bilirubin reached 36 milligrams. Dr. Burke consulted with Dr. A. O. Whipple, in New York, and it was decided that a left hepato-jejunostomy should be attempted. The second operation was performed on November 8. This time, the abdomen was opened through an upper midline incision. The left lobe of the liver presented itself. It was twice the size noted at the first operation and indicated that the desired dilatation of the intra-hepatic duct system had occurred. The right upper quadrant of the abdomen was obscured by adhesions. These were not disturbed, for it was not necessary to enter this area at this time.

Second operation: The jejunum was delivered and divided between clamps, about twelve inches from Treitz's ligament. Both ends of the divided bowel were closed by three layers of chromic 0 sutures. The mesentery of the bowel was then divided toward its base for a distance of about four inches, bleeding points being controlled by ligatures. The distal end of the proximal portion of the divided jejunum was anastomosed to the distal portion about ten inches from the point of division by a side-to-side anastomosis. This formed a shank of jejunum above the anastomosis that could be used for union with the left lobe of the liver.

A row of ribbon catgut mattress sutures was now placed across the left lobe of the liver, about three inches from the left, lateral edge. The liver was amputated one inch distal and parallel to this row of sutures. Bleeding points were controlled by tightening the mattress sutures and, where possible, by individual ligature. One, large, dilated bile duct was found near the center of the cut surface of the liver. A number 12-French catheter was passed into this for six inches. White bile was aspirated. Two smaller ducts were seen, one near each end of the cut liver surface. These were too small to permit catheterization. The catheter in the large duct was removed and replaced by a polythene plastic tube, four inches in length. This was done to prevent compression of the duct by the mattress suture which surrounded it.

The loop of previously prepared jejunum was then placed against the cut surface of the liver and opened, in its long axis, for a distance equal to the cut surface. The bowel was sutured to the liver with interrupted, chromic O sutures, so that the liver would drain into the bowel lumen. Only one row of sutures was used because of the friable nature of the hepatic tissues. After this anastomosis was completed, the closed end of the bowel (which projected beyond the liver edge) was sutured to the peritoneum of the anterior abdominal wall to prevent tension on the anastomosis. Cigaret drains were inserted down to each end of the anastomosis and brought out together through a stab-wound in the left upper quadrant. The abdomen was closed in layers, using

chromic 2 for the peritoneum, and fascia and silk for the skin.

Postoperative course: The patient's immediate postoperative condition was satisfactory. He drained a sero-sanguinous fluid for the first three days and then golden bile. On the fifth postoperative day, stools were brown in color. The serum bilirubin dropped from a high of 36 to 12 milligrams (per hundred cubic centimeters) on the sixth postoperative day.

Drainage grew less each day and had stopped completely, with healing of all wounds, on the 36th postoperative day. At this time the patient's jaundice had about disappeared clinically. Serum bilirubin was 2.8 milligrams. Stools were normal in color and he was gaining weight in a satisfactory manner. He was discharged on December 20, 1949.

Following discharge from the hospital, he continued to improve. He gained weight and was able to eat a regular diet without difficulty. Clinically, his jaundice completely disappeared. Physical examination was negative except that the right lobe of the liver was palpable just below the costal margin. Laboratory tests on January 16, 1950, showed bilirubin of 0.1 milligrams per hundred cubic centimeters. Cephalin flocculation was negative, thymol turbidity 2.5 units, total cholesterol was 299 milligrams and cholesterol esters were 149.

The patient was last seen on March 21, 1950. He had no symptoms of any kind. He was eating a regular diet and continued to gain weight. He showed no evidence of jaundice. Urine and stool were normal in color. His liver was no longer palpable.

This is the report of a case of complete obstruction of the right and left hepatic ducts treated by left hepato-jejunostomy. The patient has apparently made a satisfactory recovery. Continued observation, over a long period of time, will be necessary for the final evaluation of the case.

636 Westminster Avenue

ROLE OF THE GASTROSCOPIST IN DIAGNOSIS

JACOB A. RIESE, M.D., West New York, N. J.

Like all diagnostic procedures gastroscopy has its limitations. The average physician, unfamiliar with gastroscopy, may be so dependent on the results of an examination done by a specialist that he accepts the report as the highest of scientific evidence. He does not realize that gastroscopy, like all other diagnostic aids, is the product of the experience of the individual making the examination—that some gastroscopic examinations are technically more difficult than others—that the anatomy of the stomach may interfere with full visualization —that the make-up of the gastroscope prevents full visualization and that the interpretation of pathology is frequently a by-product of the history, physical findings and x-ray examination with all the mental acrobatics that may go into an interpretation of what is seen objectively through the scope. Frequently, as a gastro-enterologist, I have found that the x-ray report belies the clinical findings. It is my wont to emphasize to the clinician that if the scientific evidence does not fit the clinical picture, always trust in your clinical judgment. The gastroscopist renders his frequently verbose report and the unsophisticated practitioner must be wary lest he fall into the same pitfall he has been climbing out of for years as a result of too firm a belief in the eyes of the x-ray machine.

The diagnosis of stomach disease is all that can be attempted by the gastroscope. The duodenal ulcer is out of the picture. A flexible esophageal attachment can be used for esophageal inspection. Once in the stomach, the gastroscope visualizes a large portion of the organ, but not all of it. Thus a negative report may simply mean a failure to visualize the lesion and not that the lesion is absent. When a lesion is seen, there are frequent errors in differentiating benign from malignant pathology. A description of the character of the mucosa (differentiating hypertrophic from atrophic gastritis) has been the greatest gift of the gastroscopist. After gastroscopy, crude liver injection may be administered in atrophic

gastritis and antacid therapy in the hypertrophic type (frequently confused with malignancy by the roentgenologic diagnosis).

Certain factors contra-indicate gastroscopy. An x-ray examination must be made first and the gastroscopist should have the benefit of viewing the films. A lesion in the esophagus prevents the use of the gastroscope. Rigidity of neck and spine may prevent passage of the instrument. Potential or present cardiac failure may make it inadvisable to attempt gastroscopy. In the final analysis, contra-indications are best left to the judgment of the gastroscopist.

All other patients may be gastroscoped whenever the physician feels it is indicated. Being well aware of the limitations with which the gastroscopist is beset, the clinician then evaluates the gastroscopic report in the light of all other clinical and laboratory data.

Following are examples of the usefulness of gastroscopy:

CASE ONE

A 75 year old man gave a three year history of abdominal pain in both upper quadrants, and vomiting. The pain was relieved by antacids and the frequent ingestion of milk. Vomiting had occurred every three or four days. Pain was severe at night and awakened patient regularly for milk and antacids. Earlier x-rays indicated a pre-pyloric ulcer which appears to have healed under treatment. The patient had a recurrence of attacks of pain and vomiting at frequent intervals. Over the past four months, he lost 20 pounds. Pain became severe and was not amenable to the strictest type of Sippy regime. Vomiting was frequent. Gastric analysis showed a slightly increased free hydrochloric acid. X-rays revealed a defect of the antrum which was interpreted by the roentgenologist as a carcinoma. Gastroscopy disclosed areas of scarring and deformity of the antrum with a small ulcer on the lesser curvature of the antrum. The final diagnosis was benign recurrent gastric ulcer.

CASE TWO

A female of 55 has had constant burning sensation in mid-epigastrium for four years. Pain is not relieved by antacid therapy, or sedation with belladonna. She has lost ten pounds. Occasional vomiting and some loss of appetite are present. X-ray examination showed a distortion of the cardiac portion of the fundus interpreted as "possibly due to carcinoma". Gastric analysis was normal. Gastroscopy revealed a hypertrophic gastritis.

Gastroscopy is a useful aid in the diagnosis of stomach lesions. It should not be relied on to the exclusion of other examinations and should always be preceded by a gastro-intestinal series of x-rays.

6012 Palisade Avenue

PRIVACY, PATIENTS AND PRACTITIONERS

(Continued from page 362)

ance company and when it appears on his application for cash sickness benefits?

In spite of the increasing transparency of life's goldfish bowl, the clergy as a group valiantly maintain their respect for the confidence of the penitent. We of the medical profession can, with little effort, do likewise. It does not take a large measure of self discipline to keep the mouth firmly closed when there is an urge to boast about the important patient or to clothe with reality the fascinating case history. One of our arguments about state medicine is that it may well destroy the confidence of doctor-to-patient relationships. Even today, under voluntary health insurance, we have to tell the insurance company something of the patient's private life if he is to get his insurance benefits. But let's keep it between us and the insurance company. Before we point a finger of scorn at the leaking ship of state medicine, let's plug some of our own leaks.

Had an interesting case the other day. This man owns that big hardware store down on Elm Street and . . . .

SPONTANEOUS RUPTURE OF THE HEART *

CHARLES K. RATH, M.D., Elizabeth, N. J., and
H. PRESTON PRICE, M.D., Ridgewood, N. J.

An occasional but dramatic cause of sudden death is spontaneous rupture of the heart. Nine such cases have been seen at postmortem, at the Jersey City Medical Center during the fifteen-year period ending August 1, 1948. The more important clinical and pathological aspects are presented with a brief review of the literature.

Incidence. The incidence of cardiac rupture as cited by various authors is shown below. The frequency at Jersey City Medical Center was 0.3 per cent (in 3041 consecutive autopsies). This coincides closely with the large (25,000 cases) series of Edmondson and Hoxie.[1]

	Autopsies	Ruptures	Incidence
Beresford and Earl[2]	2,374	31	1.3 %
Benson *et al.*[3]	2,112	27	1.3 %
Krumbhaar and Crowell[4]	16,000	7	0.04%
Romeik (cited[4])	13,000	7	0.05%
Leipzig series (cited[4])	8,000	9	0.11%
Edmondson and Hoxie[1]	25,000	72	0.29%
Rath and Price (this report)	3,041	9	0.3 %

Pathology: All our cases of spontaneous rupture were preceded by acute myocardial infarction and followed by hemopericardium and cardiac tamponade. In seven of the nine cases there was occlusion of the left coronary artery and in two there was thrombosis of the right coronary. The infarction varied from an area 2 centimeters in diameter to involvement of the entire antero-lateral wall of the left ventricle. Microscopically, the lesions were typical of myocardial infarction and in each case consistent with the clinical duration of the infarct. The site of the rupture resembled a small laceration, the largest being 17 millimeters in length but the majority measuring one to two millimeters in length. Seven ruptures were in the lateral wall of the left ventricle, one in the right ventricle near the septum and one in the posterior wall of the left ventricle. Mural thrombosis was not described in any of the cases. Hypertrophy of the myocardium was indicated by weights varying from 400 to 650 Grams in eight of the nine hearts.

Clinical Features: The history was one of precordial or epigastric pain, often radiating to the left shoulder or back, followed in a few days by sudden death. Occasionally there was apprehension, shortness of breath or shock, but often there was no warning of the impending catastrophe. Krumbhaar[4] mentions vomiting and anginal pain as important symptoms and vertigo, cough, dyspnea and syncope as less conspicuous ones.

Case	Age	Sex	Location of Pain	Day of Death	B. P.	Day Taken
1	52	M	Epigastric and Shoulders	Fourth	0/0	Fourth
2	78	F	Epigastric rad. to back	Fifth	210/92	First
3	46	M	Precordial	Twenty-third	200/130	First
4	59	F	Precordial and Lt. Shoulder	Twelve Hrs.	105/50	First
5	52	M	Precordial	Third	130/50	First
6	58	M	Epigastric	Ninth	108/80	First
7	68	F	Epigastric	Twelfth	110/0	Sixth
8	67	F	Epigastric and Precordial	Third	205/120	First
9	57	M	Sub-sternal, Lt. Shoulder and Back	Tenth	220/130	Tenth

The rule that rupture occurs on about the fourth day following myocardial infarction was valid in only four of these cases. The table above indicates the interval between the onset of pain and the sudden death.

In this series of 3041 autopsies, 142 persons

* From the Department of Pathology, Jersey City Medical Center.

1. Edmonson, H. A., and Hoxie, H. J.: American Heart Journal, 24:719 (1942).
2. Beresford, E. H., and Earl, C. J.: Quarterly Journal of Medicine, 24:55 (1931).
3. Benson, R. L., Hunter, W. C., and Manlove, C. H.: American Journal of Pathology, 9:295 (1933).
4. Krumbhaar, E. B., and Crowell, C.: American Journal of Medical Science, 170:828 (1925).

died with old or recent myocardial infarction and nine additional patients with rupture of the heart. The incidence of infarction was 5 per cent. Sex and age incidence are indicated below:

Sex	Infarct without Rupture	Average Age	Infarct with Rupture	Average Age
Female	40	66	4	68
Male	102	61	5	52

TABLE NO. 3

It is of interest that although 10 per cent of our postmortem examinations were on members of the colored race, not one showed evidence of infarction.

CASE REPORTS

1. A 52 year old white male was found unconscious on the running board of his car. Four days earlier he had had an episode of severe epigastric pain which radiated to his shoulders. He was markedly cyanotic and died two minutes after arriving at the hospital. Postmortem examination three hours later revealed a distended, tense, bluish pericardial sac which contained 500 cubic centimeters of fluid blood and a large clot. On the anterior surface of the heart 5 millimeters lateral to the anterior descending branch of the left coronary and 4 centimeters below the atrio-ventricular groove was a vertical hiatus 17 millimeters in length, involving all layers. The anterior descending branch of the left coronary artery was occluded just below its origin. The heart weighed 322 Grams.

2. A 78 year old white woman was admitted complaining of severe epigastric pain radiating to the back, of one day's duration. She also had symptoms suggestive of a carcinoma of the stomach. Blood pressure was 210/92. The heart was enlarged and a systolic murmur was heard over the precordium. The patient was given infusions and died suddenly on the fourth hospital day without warning symptoms. Postmortem examination was performed 22 hours after death. The pericardial sac contained 250 cubic centimeters of blood and fresh blood clots. The lateral wall of the left ventricle was yellowish with red mottling and there was a one mm. perforation extending through the wall, oozing blood on pressure. Surrounding the area of perforation there was a subepicardial hematoma, measuring 3 by 2 centimeters. The heart weighed 300 Grams. The coronaries were sclerotic and there was an occlusion of the left coronary by a calcified atheromatous plaque. There was also an infiltrating adenocarcinoma of the stomach with metastases to the lungs, ovaries, tubes and bladder.

3. A 46 year old white male entered the hospital because of precordial pain of three hours' duration. Twelve hours before he had had precordial pain which lasted only five minutes; then three hours before admission, it recurred with radiation down the left arm as far as the elbow. Blood pressure was 198/130. The heart was enlarged with a regular rhythm and no murmurs were heard. Electrocardiogram was interpreted as showing a recent myocardial infarction. The patient remained comfortable for two weeks except for occasional chest pain. Three weeks after admission he became short of breath and apprehensive. Visualization with a portable x-ray showed a marked increase in the heart shadow to the right and left. A short time later the patient was found dead in bed. At postmortem examination two hours later, the pericardial cavity contained 300 cubic centimeters of dark red clotted blood. The heart weighed 650 Grams. The myocardium of the left ventricle was 16 millimeters thick; the inferior half was soft and thinned to ½ millimeter. At the tip of the left ventricle was a 5 millimeter linear rupture. The left coronary artery was occluded by an adherent brown thrombus.

4. A 59 year old white female was admitted with a severe crushing precordial pain radiating to the left arm of approximately 21 hours' duration. She had had numerous attacks of precordial pain but none as severe as this one. No history of hypertension, ankle edema or dyspnea was obtained; nor did she take any heart medication. Blood pressure was 105/50. She was in acute distress on admission with pain and profuse perspiration. The heart was not enlarged and the heart tones were of poor quality. She died three hours after admission and 24 hours after the onset of precordial pain. Postmortem examination one and one-half hours later revealed 350 cubic centimeters of bloody fluid in the pericardial sac. The heart weighed 450 Grams. The wall of the left ventricle measured 15 millimeters in thickness and the right 5 millimeters. There was a rupture of the right ventricular wall with softening of the adjacent myocardium.

5. A 52 year old white male was admitted for the treatment of diabetes. Several hours after admission he complained of precordial pain for the first time. This disappeared fifteen hours after admission. The following day he was comfortable with occasional complaints of precordial and mid-epigastric pains. On the morning of the third day he went into sudden shock and died one hour later. Admission blood pressure had been 130/50, the heart sounds distant and there was an apical systolic murmur. Diabetes was fairly well under control at the time of expiration. At postmortem examination the pericardial cavity contained about 300 cubic centimeters of fluid and clotted blood. The posterior wall of the left ventricle presented a perforation surrounded by a small area of necrotic tissue at the terminal portion of the occluded circumflex branch of the left coronary artery.

6. A 58 year old white male had a history of dyspnea, weakness, anorexia, and recurrent upper abdominal distress for six months. He had some pain across the left chest and occasionally in the left shoulder without definite precordial pain. Blood pressure was 108/80. The heart was not enlarged, the apical rate was 160 and irregular, the radial pulse 100, and no murmurs were heard. The pa-

tient did poorly on morphine, oxygen and digalen and continued to complain of abdominal pain. He died on the ninth day. Postmortem examination revealed a moderately enlarged heart with two ruptures on the anterior surface of the right ventricle about 3 millimeters from the septal junction. There was recent subpericardial hemorrhage in this area and in the extreme apex. The posterior right circumflex artery was occluded by thrombus and atheromatous plaques. Cholelithiasis was also present.

7. A 68 year old white diabetic female entered the hospital with complaints of nausea, vomiting, dizziness and drowsiness. Blood pressure was 110/0. The heart was enlarged to the left, the apex beat was forceful and the rhythm regular. An electrocardiogram showed posterior infarction. Diabetic acidosis was brought under control and the blood pressure was 150/80 three days after admission. She complained of abdominal pain the first three days and had slight but definite right upper quadrant pain interpreted as cholecystitis. Oliguria and drowsiness persisted and she died quietly on the sixth hospital day. Postmortem examination five hours later showed the pericardial cavity to contain 400 cubic centimeters of partly clotted blood. The heart weighed 400 Grams. There was a large area of infarction of the posterior wall of the left ventricle with a central one-millimeter hiatus extending through the entire wall. The circumflex branch of the right coronary artery contained a dark red thrombus 1 centimeter distal to its origin. The right ventricle was flabby. The gall bladder was normal.

8. A 67 year old white housewife was admitted with epigastric pain. Four hours prior to admission she had experienced an attack of severe pain over the upper chest, upper abdomen and back. Blood pressure was 205/120. The heart was not enlarged, the rhythm was regular and a faint systolic murmur was heard at the apex. An electrocardiogram showed acute infarction. She seemed to feel better the morning of the third day but died suddenly three hours later. Two hundred cubic centimeters of clotted blood were found in the pericardial sac at postmortem examination. The heart weighed 400 Grams. The left ventricle was soft and greyish and there was a perforation 4 centimeters from the apex. The left descending coronary was obliterated by a thrombus 6 centimeters from the apex.

9. A 57 year old white male complained of dizziness, soreness in the chest and cough of ten days' duration. Substernal pain radiated to the back and left shoulder. Physical examination revealed no cardiac abnormalities. There was no enlargement and no murmurs were heard. The blood pressure was 220/130. The patient died suddenly after fifteen hours in the hospital. Postmortem examination revealed 400 cubic centimeters of fluid and clotted blood in the pericardium. There was a small soft yellow area of infarction near the apex with a 3-millimeter rupture of the left ventricular wall located 1 cm. to the left of the anterior descending branch of the left coronary artery.

Spontaneous rupture of the heart is invariably a complication of myocardial infarction and may occur anywhere in the heart. The most frequent cause is thrombosis of the anterior descending branch of the left coronary artery with infarction of the left ventricle. The time of rupture (usually the third to the tenth day) corresponds to the period of gross softening and histologically severe myocardial necrosis with dense polymorphonuclear infiltration. Though mural thrombi are often present under the infarcted area at this stage, none of our cases of rupture possessed mural thrombi. These cases, encountered before dicumarol[5] therapy was used, led us to think that the absence of a mural thrombus might be a contributing cause of rupture. During the past year of extensive anti-coagulant therapy in myocardial infarction, however, there has been no significant increase in the incidence of spontaneous rupture. After the infarct has been replaced by fibrous tissue, rupture seldom occurs.

Hypertensive patients with coronary thrombosis are very much more likely to sustain a rupture, and this is particularly true when the hypertension persists after a clinically severe infarction. Edmondson and Hoxie[1] drew the following conclusions:

1. The degree of softening and the height of the blood pressure are the determining factors.
2. Hypertension persisting after infarction increases the likelihood of rupture three times.
3. A heart of normal weight in a hypertensive is most likely to rupture.
4. The hypertrophied heart with low blood pressure is least likely to rupture.
5. If scarring is present, rupture is only one-fourth as likely.

In their cases, the infarcts in ruptured hearts tended to be smaller, more completely necrotic and more heavily infiltrated with polymorphonuclears. The average pressure in 100 cases of non-fatal infarction was above 140/90 in 23 per cent, while 32 per cent in fatal infarcts were above this figure as compared with 63

5. Dicumarol is the collective registered trademark of the Wisconsin Research Foundation which controls the use thereof.

per cent in fatal cases with rupture. Four out of seven of our series with recorded pressures were over this figure and the others may have been earlier, as the recorded pressures of 110/0, 105/50, and 0/0 were taken shortly prior to death in the remaining three cases.

SUMMARY

1. Spontaneous rupture of the heart is an infrequent terminal episode that may occur at any time during the first four weeks following coronary thrombosis with myocardial infarction.

2. Nine cases of myocardial infarction with rupture were encountered among three thousand consecutive autopsies during the fifteen years before dicumarol[5] therapy, representing an incidence of 0.3 per cent. The clinical and pathologic features of these cases have been presented.

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MURINE (ENDEMIC) TYPHUS IN NEW JERSEY

REPORT OF A CASE

WILLIAM W. WEISSBERG, M.D., and ADOLPH J. HERZ, M.D., Elizabeth, N. J.

Only one case of murine typhus has been reported in New Jersey since 1946. The following new case should be of interest in arousing increased suspicion and alertness to this diagnosis. Murine (or endemic) typhus, is transmitted from the rat host to man by the bite of the flea vector *(xenopsylla cheopis)* or by food soiled by the excreta of the infected rat.

A 45 year old housewife, was admitted to the general medical service at the Elizabeth General Hospital* on October 22. She complained of severe headache, fever of seven days' duration, chills, profuse sweating and persistent insomnia. Though born in Russia, she had lived in the United States since the age of five; that is for 40 years. She had been in excellent health until 1947, when she developed an allergic bronchial asthma, being desensitized to dust and apples prior to present illness.

One week before admission, she developed severe frontal headache, not relieved by repeated doses of aspirin. The following day, marked generalized joint and muscle pain appeared which the patient described as "aching all over". Her oral temperature then was 101 and the headache "even worse". The second night there was marked sweating and chills. Her husband reported that she became markedly agitated.

On the third day she fainted on attempting to arise. Her temperature was 104. She had repeated bouts of chills and sweating. The headache remained intractible and the insomnia was complete. She was treated with penicillin and sulfa drugs by her private physician but symptoms persisted and she developed a nonproductive cough, a "burning" sensation over the abdomen and had several episodes of nose-bleed. After one week she was sent to the hospital for diagnosis and treatment.

We found a slender, pale, white female, acutely ill, agitated, and unable to concentrate, at times incoherent and disoriented. Temperature was 104, pulse 110, blood pressure was 120/70. Her skin was covered by perspiration. Scattered over the abdominal wall, flanks, and lower back there were numerous pinkish, macular areas measuring from one to five millimeters in diameter, which blanched on pressure. A similar rash was present over the extensor surfaces of the upper extremities. She also had a mottled erythema over the upper back.

The other positive physical findings were: sunken eyes, reddened eyelids, dry lips, whitish-brown coating with dark reddening at tip and edges of the tongue, mild neck stiffness with marked pain on complete flexion. Sibilant rales and rhonchi were heard posteriorly over the left lower lobe of the lung. There was generalized tenderness over the abdomen, but liver, kidneys and spleen were not palpable.

Laboratory findings, October 24: 3,700,000 red cells; 5100 white cells; hemoglobin 77 per cent; polymorphonuclears 36; stab cells 2; lymphocytes 52; monocytes 6; eosinophiles 2. Some of the lymphocytes were large, but not characteristic of those seen in mononucleosis.

Laboratory findings, October 29: 4,500,000 red cells; 10,200 white cells; hemoglobin 94 per cent; polymorphonuclears 66; stab cells 3; lymphocytes 30 per cent; eosinophiles 1.

Urine analyses were repeatedly negative. Sedimentation time (Westergren) was 17 millimeter/hour. The sputum was negative for acid fast bacilli.

Weil-Felix Agglutination: Negative in all dilutions for Typhoid O & H, Paratyphoid B & A and

* On medical services of Drs. H. Bloch and J. Labow.

Brucella abortus. Positive for Proteus OX19 to the dilution of 1:640 plus. Urine culture showed no growth after 24 hours. Cold agglutinins were negative in all dilutions. Feces were negative for occult blood. Culture shows a mixed growth of Aerobacter aerogenes and Escherichia coli.

Another Weil-Felix with proteus OX19, done three days after the first test was positive 1:4,000. The Wassermann and Mazzini were negative. On blood culture there was no growth of organisms after two weeks incubation.

Blood specimens were sent to the Elizabeth Board of Health, the New Jersey State Board of Health and the Communicable Disease Center at Chamblee, Georgia, with the following results:

October 31; Elizabeth: Positive OX19 in 1:5000 dilution.

November 9; State: Positive OX19 in 1:1280 dilution with negative OX2 and OXK antigents.

December 8; Chamblee, Georgia: Weil-Felix OK19 positive 1:160; OX2, OXK negative. Complement fixation tests for murine typhus positive 1:64; negative for Q fever, Rickettsial pox, and Rocky Mountain spotted fever.

These tests were repeated a month later with identical results.

X-ray of chest showed increase of lung markings in left lower lobe suggesting "probable acute infection".

Course in hospital: The patient was given 500 milligrams of aureomycin every four hours, and within 48 hours the fever dropped from 104 to 98.6, and remained normal for the duration of the hospital stay. Barbiturates were given for the first two days for restlessness. The patient was discharged on the thirteenth hospital day.

Follow-up study by the Elizabeth Board of Health revealed that the house in which the patient lived was infested with rats. The rats were not checked for typhus infection.

CONCLUSION

(1) The symptom complex of rash, intractible headache, insomnia, and fever should raise the suspicion of endemic typhus.

(2) Murine typhus responds dramatically to aureomycin.

Note: This disease is reported frequently in New York City, yet according to the Bureau of Preventable Diseases of the New Jersey State Department of Health, there have been *only 20 cases of murine typhus reported from the entire state during the past ten years.*† Why this disparity in diagnosis should exist is not accounted for by the proportional rat population. If endemic typhus is kept in mind as a distinct possibility, we believe that correct diagnosis will be made more frequently.

REPORTED CASES[1] OF TYPHUS FEVER IN NEW JERSEY 1938 TO 1949

Year	*Month*	*County*	*Area*
1938	May	Ocean	rural
1938	December	Union	suburban
1939	September	Hudson	suburban
1940	March	Essex	suburban
1940	November	Essex	urban
1940	November	Union	urban
1941	April	Hudson	urban
1941	December	Hudson	urban
1942	May	Bergen	suburban
1942	December	Middlesex	urban
1943	None	None	no cases
1944	July	Middlesex	army camp
1944	August	Cumberland	rural
1944	November	Hudson	urban
1945	August	Hudson	urban
1945	August	Middlesex	army camp
1945	October	Ocean	rural
1945	October	Essex	urban
1945	October	Essex	suburban
1945	December	Union	urban
1946	September	Union	suburban
1946	September	Essex	urban
1946	October	Union	suburban
1947	None	None	no cases
1948	August	Essex	urban
1949	October	Union	urban[2]

800 North Broad Street
925 East Jersey Street

† See table.

1. This table was prepared by the Bureau of Preventable Diseases of the New Jersey State Department of Health (Trenton) whose assistance is hereby gratefully acknowledged.
2. This is the case here reported.

18th CENTURY MEDICINE IN NEW JERSEY

Our organizational ancestors really attended their medical society meetings. They did, or else, as this extract shows. It is from the minutes of meeting of The Medical Society of New Jersey, May 10, 1774, and may be found on page 36 of the *Transactions* of that year:

"It appearing that Dr. Brown, sen., and Dr. Brown, jun., notwithstanding they have had regular notification, have never attended a meeting. The Society considers them no longer members and do order them an information of it. The Society further orders that Doctor Vanderveer be served with notice that unless he attends the next meeting, he may expect to share the same fate."

WHY NOT X-RAY BEFORE MARRIAGE?

Charles V. Craster,* M.D., D.P.H., Newark, N. J.

At the last meeting of the National Tuberculosis Association in Washington, D. C., Dr. Howard A. Rusk, reported a death rate from tuberculosis of 30 per 100,000 population in 1948, the last year for which final statistics are available. In 1904 when the National Tuberculosis Association was founded the death rate from tuberculosis was over 200 per 100,000. This represents a decline of 90 per cent since 1904. More than 50 per cent of that decrease has been since 1930.

Despite this great reduction in tuberculosis mortality in the United States, there has been recorded through the years a *great increase in the number of reported cases,* reaching 133,937 new cases in 1948. This increase is ascribed to the new and improved methods now used for the detection of early cases such as the mass x-raying of the population, in industry and many other groups.

Estimates place the number of active cases of tuberculosis in this country as 500,000 or 0.5 per cent of the nation's adult population. The program of mass x-raying every possible adult group last year (by means of small x-ray films) resulted in more than 14 million roentgenograms as compared with less than one million (exclusive of the armed services) five years ago.

Active tuberculosis was found in an average of 3 to 5 persons among each thousand apparently healthy persons x-rayed. It is estimated by Rusk that 16 million such films will be taken this year. In addition to the present groups being x-rayed, it has been recommended that a routine chest x-ray be made of all patients admitted to hospitals or treated in clinics.

In a demonstration along these lines carried out in the Morrisania City Hospital, evidence of disease was found in 10 per cent of all patients admitted and pulmonary tuberculosis in 3.6 per cent. It seems reasonable to expect that other groups of adults would yield similar results. Among no other group would this early discovery of unsuspected tuberculosis have greater value than among young adults about to embark upon matrimony, most of whom, presumably, will raise families dependent upon these individuals.

There were 9334 tuberculosis deaths in this country in 1948 in the group between the ages of 20 and 34 years. We have no way of knowing how many of these left dependent widows and children nor how many of these dependents had been infected by this disease.

In Newark alone, marriages average over five thousand per year, which would mean 10,000 men and women whose health should be checked at this important time of their lives. It is just as important that those who enter marriage, be free from tuberculosis as from syphilis, for which most states already require a pre-marital blood test.

Tuberculosis is one of our most expensive diseases both in years of life lost and in dollars. Annually an estimated 1,500,000 potential years of life are lost by those who die. The median age of persons who died of tuberculosis in 1947 was 46 as compared with 65 for cancer and 70 for heart disease. Cost of the entire tuberculosis program in the United States is estimated to be more than $350,000,000 each year. However, this vast expenditure which includes all aspects of tuberculosis control is an investment that is paying splendid dividends both in a lower death rate and a higher proportion of cures with resultant continued earning capacity.

It behooves us, however, to close the door on all avenues of tuberculosis infection, and the marriage group might well come under some inspection. If we apply military tactics in our fight against tuberculosis, every effort should be made to follow up a retreating enemy. After the battle of Gettysburg, there was some criticism of General Meade for not following up the Southern Army to destroy its capacity to make another stand. Let us not make a similar mistake in our fight against tuberculosis by neglecting to close all loopholes or possible opportunities for the disease to continue to kill and maim our people.

* Dr. Craster is the Health Officer of the City of Newark.

94 William Street

STATE ACTIVITIES

COUNTY SOCIETY MEETING DATES
1950 - 1951

County	1950 Sept.	Oct.	Nov.	Dec.	1951 Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic (Fri.)	8	13	10	8	12	9	9	13	11*	..	..
Bergen (Tues.)	12	10	14	12	9	13	13	10	8*	12	..
Burlington (Thurs.)	14	12	9	14	11	8	8	12	10*	..	..
Camden (Tues.)	..	3	7	5	2	6	6	3	1*	..	..
Cape May (Tues.)	..	24	28	26	23	27	27	24	22*	..	..
Cumberland (Tues.)	..	10	..	12	..	13	..	10*	..	12	..
Essex (Thurs.)	..	12	9	14	11	8	8	12	10*	..	..
Gloucester (Thurs.)	21	19	16	21	18	15	15	19	17*	..	..
Hudson (Tues.)	..	3	7	5	2	6	6	3	1*	..	..
Hunterdon (Tues.)	..	24	..	..	23	..	..	24*	..	..	24
Mercer (Wed.)	..	11	8	13*	10	14	14	11	9	13	..
Middlesex (Wed.)	..	18	15	20*	17	21	21	18	16	20	..
Monmouth (Wed.)	27	25	22	27	24	28	28	25*	23	27	..
Morris (Thurs.)	..	19	..	21	..	..	15	..	..	21*	..
Ocean (Wed.)	13	11	8	13	10	14	14	11	9*	13	..
Passaic (Tues.)	19	17	21	19	16	20	20	17	15*	..	..
Salem (Fri.)	15	20	17	15	19	16	16	20*	18	..	..
Somerset (Thurs.)	..	12	9	14	11	8	8	12	10	14*	..
Sussex	Sept., Dec., Feb., May — Time and place designated by Pres. and Sec'y.										
Union (Wed.)	13	..	8	..	10	..	14	11*	9	..	..
Warren (Tues.)	..	17*	..	..	16	..	..	17	..	..	17

*Annual Meeting

RESEARCH FELLOWSHIPS AVAILABLE

Research fellowships paying annual stipend of $2,200 to $3,200 are available under the sponsorship of the American College of Physicians. These provide opportunity for research in clinical investigation. For application forms and further details write to the American College of Physicians, 4200 Pine St., Philadelphia 4. Deadline is October 1, 1950.

DR. DECKER NOW FULL PROFESSOR

Dr. Henry B. Decker, 2nd vice-president of The Medical Society of New Jersey has been promoted to full professor of dermatology at the Jefferson Medical College of Philadelphia.

DR. KLINE ELECTED TO A.L.A.

Dr. O. R. Kline, a member of our Camden County Medical Society, was elected on May 29, 1950, to membership in the American Laryngological Association.

COURSE IN CURRENT ADVANCES IN MEDICINE

A full time intensive course in current advances in medicine and surgery is announced by the University of Pennsylvania for the five-day period beginning Monday, September 25. Tuition fee is $100.00 except to alumni of the Graduate School of Medicine of the University of Pennsylvania. They will be charged a fee of only $10.00.

For information and application write to the Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia 4.

SUPPLEMENTARY LIST No. 5 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Alford, Ralph I., 83 Park st., Montclair (7)
Anderson, Richard D., 465 High st., Burlington (3)
Atkinson, James Q., State Colony, New Lisbon (3)
Becker, Frank F., 337 E. Ridgewood av.,Ridgew'd(2)
Beyer, William, 612 Undercliff av., Edgewater (2)
Bibbo, Canio, 130 Kensington rd., River Edge (2)
Boyer, Philip A., Jr., 727 River rd., Teaneck (2)
Brandchaft, Bernard, 658 Springfield av., Newark(7)
Branon, Mark E., 16 W. Passaic av., Rutherford (2)
Diamond, Paul, 372 Fairview av., Westwood (2)
Eccleston, Herbert H., 124 Elm av., Hackensack (2)
Farrell, George L., 190 Euclid av., Ridgefield Pk. (2)
Fisher, James A., Jr., 601 Grand av., Asbury Pk.(13)
Galotta, Margaret L., 533 Prospect av., Hackens'k(2)
Gleason, Thomas P., 82 West Fifth st., Bayonne (9)
Gordon, Sarah, 327 Cedar Lane, Teaneck (2)
Gresser, Newton H., 286 Union st., Hackensack (2)
Higi, Joseph E., 61 Hawthorne av., E. Orange (7)
Hines, Harrison R., 710 Grand av., Asbury Park (13)
Kloth, Edward W., 254 Christie Hts. st., Leonia (2)
Krull, Bernard, 811 Queen Anne rd., Teaneck (2)
Lueddecke, R. E., 216 Randolph av., E. Ruth'rf'd (2)
Morrow, Joseph R., 45 North Broad st., Ridgew'd (2)
Neary, Edward R., 210 Carlton Terrace, Teaneck (2)
Nicholson, Frank P., 895 Summit av., Jersey City(9)
Pollack, Sol, 1906 Hudson Blvd., Union City (20)
Preminger, Max, Marcus Newcomb Hospital for Chest diseases, New Lisbon (20)
Pullen, Guy F., 111 Leonia av., Leonia (2)
Ringewald, Robert H., 284 Broad av., Leonia (2)
Rucker, William C., 308 Union st., Hackensack (2)
Samaha, Charles, 1010 Grand av., Asbury Park (13)
Scales, Harold L., 805 Red rd., Teaneck (2)
Singer, Marie J., 139 E. Madison av., Dumont (2)
Slabey, Evelyne L., 817 Abbott Blvd., Palisade (2)
Steneck, Gustav G., 275 River rd., Bogota (2)
Strenski, John, 330 Fairview st., Riverside (3)
Tepper, Victor, 2 Parkview Terrace, Newark (7)
Thomas, Francis X., 63 Mill st., Vincentown (3)
Zicardi, Anthony V., Main st., Maple Shade (3)

ASSOCIATE MEMBERS

Bookstaver, Paul I., 241 Cedar Lane, Teaneck (2)
Gamon, Adam, Jr., 240 E. Palisade av.,Englew'd (2)
Green, George G., 601 Grand av., Asbury Park (13)
Hardy, G. Robert, 93 Bayard st., New Brunsw'k(12)
Shapse, Joseph B., 786 Palisade av., Teaneck (2)
Thompson, William R., 4 W. Park av.,Park Ridge(2)

OBITUARIES

DR. FREDERICK J. HUGHES

Dr. Frederick J. Hughes, a retired practitioner, died on June 16, 1950, in his home at Plainfield.

Dr. Hughes was born in 1876 in North Plainfield. He was graduated from the University of Pennsylvania and the College of Physicians and Surgeons, New York in 1899. In 1903 he was appointed clinical assistant of Muhlenberg Hospital, in 1909, junior attending physician and surgeon and from 1914 to 1928 was senior attending physician in pediatrics. In 1928 he was named resident consultant in pediatrics, the position he held until his retirement eight years ago.

Dr. Hughes was a member of the board of Glen Gardner Sanatorium for 30 years, and the board of Bonnie Burn Sanatorium for 15 years. He served in the medical corps in France during World War I. In 1949 he was elected an emeritus member of the Union County Medical Society and The Medical Society of New Jersey.

DR. ROBERT A. CACCIARELLI

Dr. Robert A. Cacciarelli, who served on the staff of five Newark hospitals, died of a heart attack on July 11, 1950, while performing an operation.

Born in Newark in 1904, Dr. Cacciarelli was graduated from the Syracuse School of Medicine in 1927, and interned at the old Newark Memorial Hospital, now Lutheran Memorial Hospital. For the last 18 years he had been attending obstetrician and gynecologist at Columbus Hospital and consulting obstetrician at St. Barnabas's Hospital. Since 1938 he had been consulting gynecologist at American Legion Hospital. He had been attending obstetrician and gynecologist at Lutheran Memorial Hospital for five years, was on the full courtesy staff at Presbyterian Hospital and for many years was attending obstetrician at the Women's and Children's Hospital. He was a Diplomate of the American Board of Obstetrics and Gynecology.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

SCREENINGS RESULT IN REFERRALS TO PHYSICIANS

In 1949, the State Department of Health urged 7664 residents of New Jersey to go to their physicians for final diagnosis and treatment, if necessary, of conditions found in screening examinations. These included suspected cases of pulmonary tuberculosis, heart disease, cancer and other lesions of the thoracic area, and diabetes mellitus.

In a recent editorial on case-finding programs, the *Asbury Park Evening Press* made the following observation:

"Case-finding programs would appear to be a partnership in which public health authorities and voluntary health agencies find the persons needing treatment and the practicing physicians treat them. The individual patient, the physician and the public all benefit."

BORIC ACID CALLED OUTMODED AND HAZARDOUS

Boric acid should be discarded in medical practice according to an article by Dr. Harold Abramson in a recent issue of *Pediatrics*.

"Boric acid, although of doubtful therapeutic value, is used widely in a large variety of conditions," the article says. "It is a lethal agent and responsible for many unnecessary fatalities. Deaths have been reported following the ingestion of boric acid, its application to lesions of the skin and mucous membrane, its installation into serous cavities and its administration parenterally. . . . In spite of repeated warnings as to the careless use of boric acid, fatalities still occur."

The paper contains a case report, including autopsy findings, of an infant who died after its mother had applied unknown amounts of boric acid ointment to the inflamed buttocks and had dusted liberal quantities of boric acid powder onto the baby's diapers. The postmortem examination was conducted by the Chief Medical Examiner of New York City, who assisted in the preparation of the paper.

Dr. Abramson cites the findings of other contributors on this subject and carefully documents all his assertions.

"The absorption of boric acid and its diffusion in the body are rapid," the article states.

"With the absorption of toxic amounts of boric acid, symptoms referable to the gastrointestinal tract occur, such as salivation, nausea, persistent vomiting, colic-like pains and diarrhea. Subnormal temperature, circulatory depression, shock and coma ensue. Death is due to vascular collapse and central nervous system intoxication with respiratory failure. The skin may show bullous lesions or eczema-like eruptions with a patchy exfoliation. A scarlatiniform or 'boiled lobster' rash has also been noted, with subsequent desquamation on recovery. This process may extend to include the mucous membranes. Albumin and casts are found in the urine. A tubular degeneration of the kidneys is seen at autopsy. The liver is only slightly affected. The amount of boric acid and the blood levels that will produce toxic symptoms in man are not definitely known. The fatal dose is variously estimated from 15 to 30 Grams in adults and from 3 to 6 Grams in infants. . . The ease with which boric acid is absorbed through injured skin or mucous membranes is readily seen.

"Boric acid is not a mild or harmless drug. It is quickly absorbed and, in proper amounts, may readily cause toxicity and death. Boric acid exhibits a selective affinity for certain organs, such as the brain and spinal cord. When consideration is given to the extensive use of boric acid in various forms, it is surprising that more instances of poisonng have not been reported. It is possible that many cases have occurred unsuspected. Furthermore, the number of deaths from boric acid poisoning is fortunately low. These deaths may represent examples of hypersensitivity to the chemical. Nevertheless, the fatalities are needless. The doubtful benefits that are derived therapeutically from boric acid hardly justify its continued use, particularly when many more effective drugs are available.

"It is suggested that boric acid should be discarded in medical practice, since its potential toxicity represents a hazard that is out of proportion to the doubtful therapeutic value of the drug. Boric acid has been outmoded by more effective modern medications."

COUNTY SOCIETY REPORTS

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

Dr. Carl N. Ware, the president, called the regular monthly meeting of the *Cumberland County Medical Society* to order June 13, at Palatine Lake. We were the guests of the Owen-Illinois Glass Company at their club rooms.

The applications of Dr. John J. Kennedy and Dr. Harriet J. Arnold for regular membership in the Society were accepted.

Dr. Stanford W. Mulholland, professor of Urology, at the Woman's Medical College, Philadelphia, spoke to us concerning the problems in urological diagnosis. He emphasized the use of intravenous pyelogram and retrograde urography in diagnosis.

Discussion from the floor was concerned with the use of antibiotics in the treatment of urological infection. Dr. Mulholland expressed his opinion that many times these drugs developed resistant strains of bacteria making treatment more prolonged and difficult.

The dinner was served under the atmosphere of the towering cedars of South Jersey, adjoining the lake.

ESSEX COUNTY

Frank S. Forte, M.D., Reporter

The annual meeting of the *Essex County Medical Society* was held on May 11, in the Academy of Medicine, Newark.

The meeting was opened by the out-going president, Dr. Joseph I. Echikson.

The following were elected to office: Dr. Otto G. Matheke, Sr., President; Dr. Kenneth E. Gardner, President-Elect; Dr. Nicholas Antonius, First Vice-President; Dr. William H. Hahn, Second Vice-President; Dr. Marcus Greifinger, Secretary; Dr. Edwin Steiner, Treasurer; Dr. Elizabeth Brackett, Reporter.

The following were the newly elected members of the Council: Drs. E. M. Katzin, Joseph A. Clarken, and Frank S. Forte.

Dr. H. S. Connamacher made the annual memorial announcement.

Another highlight of the meeting was an enlightening talk by Mr. James E. Bryan, executive officer of The Medical Society of New Jersey. He reported that progress has been made in our battle against compulsory health insurance, but this progress is only the spade work for that which must be done by all in the immediate future.

Dr. Echikson, then made his presidential address. This excellent talk urged doctors to assume their rightful community responsibility and leadership.

Dr. Harrold A. Murray, made the presentation of the presidential key to the outgoing president, Dr. Echikson.

With the close of this meeting a great president and community spirited doctor moved over to the illustrious ranks of our former presidents.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

J. Paul Burkett, M.D., presided at the May meeting of the *Gloucester County Medical Society* held on the evening of the 18th at the Woodbury Country Club. I. N. Patterson, M.D., Chairman of the Program Committee presented Mr. George Lamb, Gloucester County Agricultural Agent, who in turn introduced Dr. Wiltsey of the American Cyanamid Co. Dr. Wiltsey discussed the powerful new insecticide, parathione, mentioning the symptoms of poisoning, treatment, antidotes, precautions, et cetera.

Mrs. Miriam F. Black, American Red Cross field representative, went over the blood bank program, stating that Gloucester County is somewhat behind in its contributions and asking the physicians to cooperate by emphasizing the need for blood-giving by their patients.

The scientific program was presented by Alfred Shands, M.D., medical director of the Alfred I. DuPont Institute. This illustrated presentation concerning crippled children, their problems and care, was very well received by the few members present.

Wendell Burkett, M.D., of the Legislative Committee discussed the 1-10-20 plan and the ever-present need for our undivided concentration on the future of medicine. Dr. Burkett also suggested that the society write to our representative in the House to determine definitely how he stands on "socialized medicine".

The following panel of officers was elected unanimously: President, A. Guy Campo, M.D., Westville; Vice-President, Anthony J. DiMarino, M.D., Paulsboro; Secretary, Clarence A. Bowersox, M.D., Woodbury; Treasurer, Joseph F. Hughes, M.D., Woodbury; Historian, Dorothy M. Rogers, M.D., Woodbury; Reporter, Louis K. Collins, M.D., Glassboro.

President A. Guy Campo was ushered to the chair and announced the following committee appointments:

Program: Drs. Collins, Kehler, Battaglia; Maternal Welfare: Drs. Faux, Underwood, Rogers; Public Relations: Drs. J. P. Burkett, DiMarino, Wentzell; Public Health: Drs. Ulmer, LaRosa, Laurusonis; Child Health: Drs. Pegau, Beall, S. T. Campo; Legislative: Drs. W. J. Burkett, Patterson, Puff; Cancer: Drs. Underwood, Livengood, Wandall; School Health: Drs. Pedrick, Brewer, Sheets; Adviser to Woman's Auxiliary: Dr. Ulmer.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its eighth and final meeting of the official year on May 2, at Murdoch Hall, Jersey City Medical Center. Dr. Butler presided.

Annual reports of the committees were read and accepted.

The following were elected to membership: Dr. Joseph T. Carey of East Newark, Dr. Samuel E. Feinman and Dr. Joseph A. Lucci of Jersey City.

The Secretary cast one ballot for the election of the following officers for 1950-1951: *President,* Dr. Noah Meyerson; *Vice-President,* Dr. William J. Gleeson; *Secretary,* Dr. Joseph P. Donnelly; *Treasurer,* Dr. Anthony J. Conty; *Reporter,* Dr. Harry J. Perlberg.

Community Fund: The meeting was addressed by Mr. Edward Johnson and Mr. John Q. Adams, speaking in behalf of the 1950 Campaign Fund of Community Chest. Briefly describing the operation of Community Chest as it assists its participating member-organizations, Mr. Johnson and Mr. Adams entreated the medical profession to contribute as generously as possible this year.

The main speaker of the evening was Dr. James F. Norton, president of The Medical Society of New Jersey and vice-president of the American Medical Association, who addressed the members of his home county medical society on the twelve-point "Proposals of The Medical Society of New Jersey for a National Health and Medical Care Program". After discussing his plan point by point, Dr. Norton took part in an animated discussion of the proposals with members from the floor. The "Norton Plan" will be submitted to the American Medical Association for consideration as the basis of a national voluntary health program when the Association meets in San Francisco on June 26-30, 1950. Many constituent state medical societies will join New Jersey in sponsoring these proposals before the House of Delegates of the national organization.

This meeting terminating Dr. Butler's tenure of office, he thanked the entire membership for its support of his program during the closing year, paying tribute to his fellow-officers.

Dr. Meyerson expressed his appreciation of the honor conferred upon him and briefly stated his objectives during the coming year.

MIDDLESEX COUNTY

Martha F. Leonard, M.D., Reporter

The regular meeting of the *Middlesex County Medical Society* convened at the Roosevelt Hospital on May 17.

On the recommendation of the Medical Ethics Committee the resignation of Dr. I. E. Sadoff was accepted.

A letter was read from the Union County Medical Society announcing their proposals to the state and national medical societies for improving the intern supply to smaller hospitals, namely the use of two year internships—straight, rotating, or one year of each—and the allotment of interns to hospitals on the basis of number of patients or number of admissions. The Middlesex County delegates to the State County meetings were advised to give these proposals their support.

The president, Dr. Fine, reminded the members that 1950 American Medical Association dues of $25.00 are payable to the State Medical Society.

On the motion of Dr. Clark, it was voted to make Dr. H. W. Haight an honorary member of the Society as of 1948.

At Dr. Clark's suggestion, Rutgers University has invited the State Medical Society to hold its fall clinical meetings on the University campus in New Brunswick. It was voted that the president of the County Society write to the Board of Trustees augmenting this invitation and offering the services of the County Society as hosts for these meetings.

Dr. Van Mater reported that following the American Chamber of Commerce's stand opposing socialized medicine, the New Brunswick Chamber of Commerce has offered to help the Medical Society in its campaign against socialized medicine. In return, physicians were urged to join their local chamber of commerce.

Dr. Clark then introduced the speaker of the evening, Dr. Fred G. Medinger, director of the Tumor Clinic of Abington Memorial Hospital, who spoke on "Cancer of the Mouth and Jaws".

On June 21, the regular monthly meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. H. P. Fine. Following reading of the minutes, a series of letters from The Medical Society of New Jersey was read.

A letter from Dr. Ira T. Spencer thanked the members for his nomination as general practitioner of 1950. Dr. Rowland suggested that Dr. Spencer should also be recommended for honorary membership to the State Society. On the motion of Dr. Sherman it was agreed to appoint a committee to arrange a dinner dance in September to honor Dr. and Mrs. Spencer, with expenses being covered by assessment of members who attend.

Physicians' Post No. 445 of the American Legion wrote requesting the Society's active disapproval of Senate Bill No. 2008 concerning organization of all health services, including Army, Navy and Veterans Administration medicine in one large government department. Dr. Taber suggested obtaining from the A.M.A. full information concerning Senate Bill No. 2008 and item No. 27 of the Hoover Reorganization Plan.

Dr. Fine announced that 117 of the county's 211 doctors had paid their A.M.A. dues.

Dr. Perillo announced the publication by the Children's Bureau and the National office of Vital Statistics of the pamphlet "Confidential Nature of Birth Records", Children's Bureau Publication No. 333—1949, available free on request.

Dr. Fine reported briefly on the State Convention, recommending continuing the policy of engaging a suite for the use of the County Society delegates.

Dr. Van Mater, reporting for the 1-10-20 committee, urged each physician to contact 20 lay people, convince them of the advantages of voluntary over state controlled prepaid medical care and encourage them to spread information to other lay audiences. Discussing the recent statement to the Labor Institute at Rutgers University by Dr. Somberg of Newark, that he favored the Wagner-Murray-Dingell Bill, Dr. Van Mater recommended that this County Society send letters to Dr. Som-

berg and to the Essex County Medical Society protesting the action of this physician in openly recommending a bill to which all the members of this Society are opposed.

Dr. Fine announced the creation of a civilian defense committee in view of our unpreparedness in the South Amboy explosion. The physicians' committee consists of Dr. Marshall Smith, Chairman, Dr. F. S. Taber, Dr. C. W. Hoffman, Dr. C. J. Hutner, Dr. S. G. Berkow, and Dr. C. Morris. An additional advisory committee is composed of Mr. Morrison from St. Peter's Hospital, Mr. Brown from Middlesex General Hospital, Mrs. Susan O'Brien from South Amboy Hospital and Mr. Anthony Eckert from Perth Amboy General Hospital. Dr. Smith stressed the importance of civilian defense in view of the history of 32 major industrial disasters in New Jersey in 25 years, and the fact that this group would serve as county representatives of the State and National defense councils. Both sectional and county control centers will probably be in New Brunswick. Plans include setting up means of communication during a disaster, assignment of all doctors and nurses in the county to strategic posts, creation of teams to work in each hospital, standardization of treatment, especially of burns, and distribution of casualties through cooperation of ambulances, first aid squads and police cars. The local chiefs of medical services—Dr. Sherman, Dr. Berkow, Dr. Hesseltine, and Dr. Hutner were endorsed by the Society. The creation of an advisory committee to standardize the treatment of burns and to advise the New Jersey Committee for first aid in instructions to first aiders, particularly in handling burned cases was approved and the committee is to be appointed by Dr. Fine.

On motion of Dr. Becker the creation of a General Practitioners' Committee for the County Society was approved.

Dr. Shangold announced the request of the Metuchen Chapter of the American Red Cross that the County Society sponsor the establishment of a blood bank as part of the national blood bank program. This matter was referred to the Blood Bank Committee.

The scientific session featured an illustrated lecture by DR. JOSEPH L. MORSE, assistant clinical professor of Dermatology, New York Post-Graduate Medical College-Bellevue Medical Center, on "Occupational Dermatoses".

MORRIS COUNTY

Theodore R. Failmezger, M.D., Reporter

The annual year of the *Morris County Medical Society* came to a close with a dinner meeting at the Spring Brook Country Club in Morristown on June 15. After cocktails and a delicious steak dinner the business meeting began with discussion of the reports of the various committees.

The prizes for the afternoon golf tournament were distributed and it seems that the only prerequisite to getting a prize was to have the fortitude to withstand the elements during the afternoon rain. We hope next year the weather will be more favorable and that our golfers will at least have a little more competition for the prizes.

Mr. Moore from the Hospital Service Plan of New Jersey spoke to the group and it was decided that the Society would go in as a group, appointing someone to handle the administrative end, thereby reducing the cost of hospitalization to each member. It was also decided to join the Medical-Surgical Plan in the same manner, provided there were sufficient members interested.

Dr. James F. Norton then spoke primarily about the New Jersey Plan which he is to present to the A.M.A. Convention. The group seem to be sincerely behind him in recognizing the fact, first, that there is need for such medical service in the United States, and second, that we feel this plan best meets the needs.

The yearly anticipated report of our chairman of the delegates to the State Convention, Dr. Clyde Bowers, was, as usual, informative, complete and humorous. We feel that this report is one of the outstanding highlights of our yearly dinner meeting and we always look forward with more than pleasure and gratitude to its presentation.

The meeting was closed after the induction of our new president, DR. J. HENRY HARRINGTON, who for many years was treasurer of the County Society and has been keenly interested and active in our organization. We wish him well in his new endeavor.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

The regular meeting of the *Union County Medical Society* was opened by its newly-elected president, DR. HERSCHEL S. MURPHY, on May 10. Our host for this meeting was the Ciba Pharmaceutical Products, Inc., Summit. The medical department of this company showed an interesting film, *"Treatment of Leukorrhoea"*.

Upon recommendation of the membership committee, DR. EARL A. O'NEIL of Plainfield, was elected to full membership.

It was announced that the annual outing of the society would be held on October 11, 1950, at the Colonia Country Club, Colonia.

There was a prolonged discussion on the new fee-schedule of the Medical-Surgical Plan.

It was announced that the dues for the society had been raised to $15 per year to enable the society to meet its ever increasing financial expenses.

DR. NORMAN W. BURRITT, of Summit, introduced a resolution regarding nurses' training, the unfairness of the restrictions which are preventing many nursing schools from securing adequate enrollments, and urging a more thorough investigation of the problem as it relates to the medical profession. By unanimous vote of this society, Dr. Burritt was authorized to present his resolution before the House of Delegates of The Medical Society of New Jersey in Atlantic City.

The speaker of the evening was DR. ERNEST W. LAMPE, assistant professor of Surgery, Cornell Medical College, New York City, who presented a most interesting paper on *Surgery of Hand Infections*.

WOMAN'S AUXILIARY

A TRIBUTE TO MRS. DAVID B. ALLMAN

Mrs. R. John Cottone, President

It is a rare privilege and a singular honor for New Jersey to send a President to the Woman's Auxiliary to the American Medical Association and so, with a feeling of great pride and gratitude, we welcome home our own Mrs. David B. Allman, immediate Past-President of our national organization.

We have watched with justifiable pride the successful advance of the work of our Auxiliaries throughout our great nation as she has given unsparingly and unselfishly of her time, visiting state and county auxiliaries, promoting national programs, leading health conferences and board meetings and helping wherever she was called, thus traveling constantly during the entire year, to almost every state in the union.

Through her leadership, in this time of crisis when the freedom of organized medicine is threatened on every side, doctors' wives everywhere, by united effort, have worked diligently and effectively to combat this evil. State officers from Maine to California have been warm in their praise of her leadership and appreciative of her gracious and kind friendliness. The trustees of The Medical Society of New Jersey contributed their recognition of the high honor she has brought to our state by her elevation to the highest office in the Woman's Auxiliary to the American Medical Association.

Her many friends at home rejoiced to learn of the splendid tributes and honors given her at the recent Convention in San Francisco.

We of the Woman's Auxiliary to The Medical Society of New Jersey have reaped the harvest of Mrs. Allman's successful year as national President and it is with deep appreciation and sincere respect that we wish her many years of good health and happiness, confident that she will continue to serve the cause of health and humanity through her wise counsel gained by many years of valuable experience.

CONVENTION MEETINGS

Mrs. Thomas H. McGlade

The Woman's Auxiliary to The Medical Society of New Jersey held its Annual Convention at the Haddon Hall, Atlantic City, N. J., May 22, 23 and 24, 1950. A preconvention board meeting was called by the president, Mrs. Norman Nathanson on May 22. Twenty-eight members responded to roll call. Mrs. Jesse T. Glazier, Safety Chairman, announced the following counties participated in a survey of home accidents: Atlantic, Burlington, Cape May, Hunterdon, Mercer, Ocean, Passaic and Salem. Mrs. Asher Yaguda lauded Mrs. Don Epler for her splendid work with the 1-10-20 Plan. Mrs. Epler obtained a majority of the resolutions credited to Essex County. The resignation of Mrs. Franceso Figurelli was accepted with regret. Mrs. Robert B. Walker and Mrs. William E. Dodd were appointed to the Auditing Committee.

A group of Panel Discussions immediately followed the board meeting. Participating in the various groups were:

Public Relations—Mrs. Paul E. Rauschenbach, Moderator, Mrs. William Bray, Mrs. John Kustrup and Dr. William Bray.

Legislation—Mrs. Oswald R. Carlander, Moderator, Mrs. Wilmer F. Burns, Mrs. Peter J. DeBell Mrs. Frederick G. Wandall and Mrs. Bertram Sauerbrunn.

1-10-20 Plan—Mrs. Asher Yaguda, Moderator, Mrs. J. S. Eisenhower and Mr. James Bryan.

Look! Your Programs Are Showing—Mrs. Franke Forte, Moderator, Miss Grace Hornaday and Mrs. Jessie T. Glazier.

What's Wrong With the Auxiliary?—Mrs. Richard H. Demaree, Moderator, Mrs. Irving Baer, Mrs. Peter J. DeBell, Mrs. John Kustrup, Mrs. Thomas H. McGlade, Mrs. C. Scott McKinley, Mrs. Bertram Sauerbrunn and Mrs. John C. Voss.

The Convention was declared in session on May 23, 1950. It opened with the Pledge of Loyalty to the Woman's Auxiliary and the Invocation. Mrs. Harry Subin, Convention Chairman, welcomed the Convention. Mrs. R. John Cottone. president-elect of the State Auxiliary responding to the greeting, complimented Mrs. Subin and her entire committee for their geniality and capability in the successful handling of the Convention.

Mrs. David B. Allman, President of the Woman's Auxiliary to the American Medical Association was presented. Mrs. George Rogers opened the Memorial Service for departed members with the Prayer of St. Francis of Assisi. Those listed in memoriam were: Mrs. A. Dunbar Hutchinson and Mrs. E. B. Woodward of Mercer County, Mrs. M. S. Meinzer, Middlesex County, and Mrs. John S. Dunn of Salem County. At the close of the ceremony, Mrs. Rogers presented a Memorial Vase, the gift of the Fellowettes to the Auxiliary, in memory of those who had passed away.

Mrs. Edward Dyer, Credentials Chairman, reported 202 members registered at 10 a. m. on May 23, 1950. The usual reports were read. The treasurer's report (with the attestation of the auditors report) was accepted. Elected to serve on the nominating committee were: Mrs. David B. Allman, Mrs. William E. Dodd, Mrs. R. J. MacDonald and Mrs. Philip J. Santora. Mrs. Arthur J. Casselman and Mrs. Thomas P. McConaghy were appointed as a reading committee. The panel of candidates offered by Mrs. Robert B. Walker, Nominations Chairman, were read and the officers duly elected.

The annual gala affair of the Convention was the luncheon honoring Mrs. Norman Nathanson. The Benjamin West Room served as a fitting background for the ladies looking their loveliest on this festive occasion. The striking and very capable Mrs. Asher Yaguda served as toastmistress. She called upon fourteen past presidents to rise and state the year in which they served as president of the State Auxiliary. Other honored guests were: Mrs. William J. Lavelle of the New York Auxiliary, Mrs. Charles Bailey of the Pennsylvania State Auxiliary and Mrs. Edward Byers of the Montgomery County Auxiliary, and Thomas F. Dulaney, Jr., Executive Director for the Chronically Ill of New Jersey and Dr. Norman Nathanson. Dr. Lloyd A. Hamilton, upon his introduction, said it was a pleasure to work with Mrs. Nathanson. Dr. Clara Renner was introduced as an honorary member of our State Auxiliary. Mrs. Norman Nathanson attributed her success to the unselfish cooperation of every member of the Auxiliary. She said no trip in the state, was too long because warm friends would be there to greet her. Mrs. David B. Allman brought greetings from the National Auxiliary and urged those present to fight to continue the American way of service. Mrs. Allman stated she was proud of New Jersey and felt obligated to her state and county for all they had done and wished to see many in San Francisco, at the National Convention.

Guest speaker of the afternoon was Dr. James F. Norton. He said that we are a fine and efficient Auxiliary which has accomplished much and done a tremendous job. We are headed in the right direction and the Medical Society is indebted to us. He then, read the paragraph of his report to the House of Delegates in which he expressed his gratitude to the Auxliary and commended them on the work they had done. The past president's pin was presented by Mrs. Robert B. Walker, junior member of the Fellowettes. The Auxiliary members were directed to attend the general session of the Medical Society to which they had been invited for the first time.

The Inaugural Breakfast of the Auxiliary took place on May 24. Professor Reager gave a most stimulating and interesting talk. He emphasized the importance of projecting friendliness in our voices, together with quality and roundness of tone. He suggested using few and well selected words in telling a story and avoiding an argumentative inflection.

Dr. Aldrich C. Crowe, incoming President of the Medical Society, stated he was proud of the Auxiliary and will give it every support.

Mrs. Norman Nathanson then called the meeting to order and proceeded with the roll call. Mrs. Irving Baer, substitute chairman on Resolutions, submitted a resolution to be presented to Mrs. Norman Scott expressing the sympathy of the Auxiliary over the death of Dr. Scott. Resolutions were also offered extending the thanks of the Auxiliary to Dr. James F. Norton, Mrs. James H. Mason, Honorary Chairman, Mrs. Harry Subin, General Chairman, Mrs. Robert A. Bradley, Co-Chairman and the members of their committee, Mrs. Edith L. Madden, Convention Manager, the Management of the Chalfont-Haddon Hall and the Fleming Hall Tobacco Company. Mrs. Dyer, Credentials Chairman, reported 268 members registered at the Convention. Installation of the Officers was followed by the presentation of the Gavel to Mrs. R. John Cottone. Mrs. Nathanson then, officially closed the Convention.

POST CONVENTION BOARD MEETING

Mrs. R. John Cottone, upon acceptance of the gavel, assumed the role of president and continued the meeting. Mrs. Cottone announced her committee appointments and read her program for the coming year. The treasurer, Mrs. Asher Yaguda, presented her proposed budget for 1950-1951 which was accepted. Mrs. D. Leo Haggerty was elected to fill the vacant post of direcor on the executive board. Mrs. Maurice Chester of Salem County, presented a photograph of the first convention of the Auxiliary to The Medical Society of New Jersey taken in 1928 to Mrs. Cottone, to be placed in the archives. Mrs. Asher Yaguda announced that an all day forum "School Health Services in New Jersey" will be held on June 5, 1950, in Trenton. Mrs. Andrew Ruoff announced that copies of the Constitution and the *Handbook* will be mailed to the members of the Executive Board. Adjournment followed the presentation, by Mrs. John Kustrup, of a gift to Mrs. Cottone in behalf of the Auxiliary members of Mercer County.

SCHOOL OF INSTRUCTION

Twenty-five members, representing twelve counties, were present at the school of instruction for county presidents held on May 24. Mrs. Allman suggested following the outline printed in the May issue of the *National Bulletin* of the Woman's Auxiliary. She also advised greater use of the *Handbook,* which is being revised, and the Pledge of Loyalty at all meetings. Mrs. Oswald R. Carlander, Legislation Chairman, outlining work for the summer suggested chairmen study bills and assist in the 1-10-20 Plan. She also listed material and sources of information to be used in the study of legislation. Mrs. J. S. Eisenhower, Rural Health Chairman, announced films available for programs. Mrs. Asher Yaguda, 1-10-20 Plan Chairman, urged Auxiliaries to continue securing endorsements and suggested contacting churches for same. Mrs. R. Louis Silverman, Nurse Recruitment Chairman, announced county chairmen would receive instructions through the mail. Mrs. Arthur P. Trewhella, *News-Bulletin,* solicited suggestions and urged cooperation in compiling materal for the state paper. A question and answer period preceded the motion for adjournment.

AUXILIARY REPORT

Essex County

Mrs. Stuart Z. Hawkes,
Chairman, Press and Publicity

Our annual meeting and luncheon was held on May 15 at the Robert Treat Hotel, Newark. Nearly one hundred members attended the luncheon, which was a real recognition of the fine work our president, Mrs. Philip Santora, has done.

Following the greetings by the president, and the invocation by Mrs. Philip D'Ambola, the president turned the meeting over to Mrs. Pascal Baiocchi, Program chairman. Mrs. Baiocchi presented our guests: Dr. Joseph Echickson, Jr., Past-President of the Essex County Medical Society, Dr. Otto Matheke, Sr., President of the Society and Dr. Kenneth Gardner, President-Elect of the Society and Auxiliary Adviser.

Mrs. C. Joseph Ferri, one of our members, sang several songs, accompanied at the piano by another member, Mrs. Jules Perelman.

Two of our honored luncheon guests were the recipients of this year's Nurse-Scholarship awards. They are Miss Joan Chilenski and Miss Dolores Benimelli, who were presented by the chairman of the Nurse-Scholarship committee, Mrs. Andrew Klein.

Following the reading of the annual report by the president, and the presentation of the Past-President's pin to Mrs. Santora by the junior past-president, Mrs. Robert Anderson, Mrs. Santora greeted the new officers of the Auxiliary.

Mrs. Jesse T. Glazier of Newark was installed as president. She has just finished her term as president of the Suburban Woman's Club of Irvington. The following officers were also installed: President-Elect, Mrs. John Torppey of Glen Ridge; First Vice-President, Mrs. Pascal Baiocchi of East Orange; Second Vice-President, Mrs. Jerome Kaufman of Newark; Recording Secretary, Mrs. W. Alan Wright of East Orange; Treasurer, Mrs. Ralph R. Autorino of Montclair; Secretary to the Treasurer, Mrs. Philip D'Ambola of Harrison; Directors, Mrs. Anthony Ambrose and Mrs. Joseph Clarken of Newark; Mrs. Stuart Hawkes of Boonton, and Mrs. Charles Minnefor of South Orange. Mrs. Glazier appointed Mrs. John Pannullo of Newark as Corresponding Secretary.

The following resolution was passed: Be it resolved that we, the members of the Woman's Auxiliary to the Essex County Medical Society, are unequivocally opposed to compulsory health insurance. Be it further resolved, that copies of this resolution be sent to the United States Senators and the Representatives from New Jersey, the press and the Resolutions Chairman of the Medical Auxiliary.

BOOK REVIEWS

Human Growth. By Lester F. Beck, Ph.D. Pp. 124. New York, Harcourt, Brace and Company, 1949. ($2.00)

Human Growth, which is based on the educational film of the same title, is a book on sex education for teen-age children. Physicians and educators can recommend it for adolescent children and, also, for parents who have the important task of helping young people achieve a wholesome view of life and growth.

What adolescents, youths and teen-agers should know about conception, reproduction, birth, general growth after birth, menstruation and puberty, is presented scientifically yet in simple and straightforward terms.

The illustrations are adequate and self-explanatory. At the end of each chapter is a list of questions that children may ask. A glossary of medical terms is provided and will be an aid to both parents and children.

Joseph E. Mast, M.D.

The Arthropathies — A Handbook of Roentgen Diagnosis. By Alfred A. de Lorimier, M.D. 2d ed. Pp. 335. Chicago, Year Book Publishers, Inc., 1949 ($7.00)

The second edition of this book has been extensively revised. The illustrations are clear, and have been improved since the first edition. The text is concise. The roentgen criteria for diagnosis of each entity are well stated. Emphasis is placed on systematic examination of roentgenograms of the joints, with attention directed to study of soft tissues, regional bones, articular cortexes, joint space, and by indirect evidence the articular cartilage and synovial membrane and joint capsule. All material is well organized, and for a handbook, it offers good coverage of the subject.

Jules H. Bromberg, M.D.

Monographs on Surgery, 1950. Edited by B. Noland Carter, M.D. Pp. 501. New York, Thomas Nelson & Sons, 1949. ($15.00)

These monographs are published in place of the yearly issue of "Loose-leaf Surgery". They present the recent signal advances in general surgery, gynecology, urology and orthopedics. Each subject is treated with thoroughness and completeness. The printing is good and makes for easy reading. And a comprehensive bibliography is found at the end of each title. The chapter on chemotherapy in surgery covers the use of sulfonamides and antibiotics briefly but to the point. The second chapter treats carcinoma of the lung and places emphasis on early diagnosis and complete extirpation of the tumor and regional lymph nodes as the only chance for cure. A fall in operative mortality from 50 per cent in 1940 to 15 per cent in 1948 is reported. The chapter on pancreatitis is the most thorough. It leaves one with the feeling that conservatism in regard to surgery is the trend.

In a similar manner the following subjects are covered: carcinoma of the endometrium, infections of the urinary tract, bone bank, medullary fixation of fractures, and arthrodesis of the spine. Each contributor presents the consensus of the literature, filtered through his own experience.

Irving Maisel, M.D.

Current Therapy — 1950; Latest Approved Methods of Treatment for the Practicing Physician. Edited by Howard F. Conn, M.D. Pp. 736. Philadelphia, W. B. Saunders Co., 1950. ($10.00)

Current Therapy, 1950 is a somewhat expanded version of the earlier edition of 1949. Much of the former work has been repeated. A number of additions have been made, keeping pace particularly with the changing picture in the treatment of the infectious diseases since the introduction of aureomycin and chloromycetin. The thoroughness of the edition is displayed by the inclusion of some of the responses to ACTH and cortisone in gout, rheumatic fever, rheumatoid arthritis, and disseminated lupus erythematosus.

The present edition continues to display the technical excellence of its predecessor, and it will continue to be an avidly used rapid reference book.

Henry Green, M.D.

Diseases of the Foot. By Emil D. W. Hauser, M.D. 2d ed. Pp. 415. W. B. Saunders Company, Philadelphia, 1950. ($7.00)

Dr. Hauser has made many noteworthy contributions to orthopedic literature and his feelings on shoe corrections for functional disorders (consisting of Thomas heels and the comma shaped transverse bar) are found throughout the book. The chapter on "Postural Disturbances and the Foot" excellently correlates his theories of functional decompensation as related to all the joints of the lower extremity and up to and including the lumbar spine. The author uses the term "arthosis" for that type of arthritis resulting from irritation due to repeated traumata, the latter arising on a static basis. The compilation of these conditions in almost all the small joints of the foot into one chapter is noteworthy of mention. The surgical and conservative treatment of each is well presented.

The cohesive bandage treatment of congenital calcaneo-valgus and congenital club foot is presented in minute detail. Little mention is made of properly applying plaster of paris corrective bandages for these congenital disorders. The only brace or mechanism mentioned to maintain the foot corrections is the Hauser brace. It is a pair of parallel horizontal bars connecting the shoes and hinged at the margins of the shoes.

The chapters on fractures and dislocations are short and vague, but representative cases of fractures of the various foot bones are well handled. Space is devoted to the ostcochondrotides and the various tumors of the foot. These are treated concisely and clearly and should be of great assistance to the general practitioner. Similarly, the presentation of

the circulatory disturbances of the foot is short but complete; little mention is made of the newer vasodilator drugs.

The care of the skin and nails and the treatment of disorders that may appear in these organs are well covered. A complete chapter on methods of manipulation of the foot utilizing Haglund footboards and Thomas wrenches may be misleading to the reader who uses little or no manipulation in his practice.

This brief review fails to reveal the excellent organization and clear quality of the book. Methods of diagnosis and treatment are direct and practical. Every possible disorder of the human foot is mentioned. This covers the minor complaints which so often puzzle the general practitioner as well as the uncommon diseases which even the orthopedist may never see. This book is recommended for any practitioner who may treat diseases of the foot.

Herman Lohman, M.D.

Postgraduate Gastroenterology. Henry L. Bockus, M.D.—Editor. W. B. Saunders Company, Philadelphia, 1950, Pp. 670. ($10.00)

Specialists in the subject will find considerable material of interest in this book by one of the deans of gastroenterology in America. It provides in one compact volume the important views on a number of diseases of the intestinal tract. This small text is a permanent record of the proceedings of a one week course given under the auspices of the American College of Physicians just a little more than a year ago and therefore touches only briefly upon these views.

Consideration of various topics are in the form of symposia, in which the more recent advances and the controversial opinions of the organ or disease are discussed. Each is followed by a question and answer period or a panel discussion. In these informal periods, many controversies are clarified. The chapter on the application of neuropsychiatry to gastrointestinal problems deserves special mention as does the comment made by Dr. Bockus: "I wish that these messages . . . . could be broadcast throughout the length of this land".

The symposia on the liver, the pancreas, the mechanism of abdominal pain, on jaundice and on colonic diseases are excellent. The chapter on peptic ulcer brings the reader up to date. Recent advances of the knowledge in gastric secretion, as well as various phases of gastric neoplasms (to mention only a few of the remaining topics) are adequately presented. Numerous reproductions of roentgen findings appear throughout the book. Their clarity cannot be excelled and they really illustrate. Some of the volume is devoted to case presentations in which some unusual problems are vividly described and discussed in lively fashion. Although the course was given primarily as a refresher for gastroenterologists, it is a useful general volume well worth the shelf space for any physician interested in diseases of the gastrointestinal tract.

Sydney Rosenthal, M.D.

The Law of Medicine. By Parnell Callahan, L.L.B., and Justin Callahan, M.D. Oceana Publications, New York 11, N. Y. Pp. 80. 1950. ($2.00 cloth or $1.00 paper.)

"Prohibited operations" according to page 6 of this brochure, include transfusion and circumcision. Other bits of information in this booklet are: ". . . in appearing before a compensation board a physician will always be asked to state his compensation rating. These ratings are A—General Surgery, Major, B—Orthopedic surgery. . .". (Actually this is true of New York and a few other states only. This type of 'compensation rating' is unknown in most states.) We also learn from this little book that the International College of Surgeons and similar organizations are associations of diplomates. We are told that the "administration of drugs is the exclusive prerogative of physicians", a fact which will surprise the dentists of the country. On page 80 we learn that a psychosis is a "definite disease of the mind, usually without any organic lesion."—a definition which makes us wonder how to rate the arteriosclerotic and encephalitic psychoses, and how to classify such mental disorders as psychopathic personality which are surely diseases of the mind without being psychoses. A neurosis is defined as "any morbid nervous state". New Jersey doctors will be surprised to learn that a practical nurse is a "person holding a certificate as a trained attendant." This little book, in fact, is full of surprises. And it has no index.

Ulysses M. Frank, M.D.

Brucellosis (Undulant Fever); Clinical and Subclinical. By Harold J. Harris, M.D., with the assistance of Blanche L. Stevenson, R.N. 2d ed. Pp. 617. New York, Paul B. Hoeber, Inc., 1950. ($10.00)

It is becoming more evident to physicians in general practice and the specialties that brucellosis must be included regularly in their differential diagnostic problems. About 10 per cent of the population of the United States has become infected and about 10 per cent of that number are actively and clinically ill with the disease. Dr. Harris presents a practical study of this disease, which he developed from close observation of 700 patients over a period of years. In this new second edition, the management of every type of case is covered in detail, including the use of aureomycin and other antibiotics.

He clearly describes the important elements in the diagnosis of undulant fever, and points out the commonest errors in this diagnosis. He cautions that low grade fever should never be the basis for diagnosis of brucellosis unless accompanied by other clinical and acceptable evidence of Brucella infection. On the other hand, the burden of proof that low grade fever is of psychogenic origin rests upon the physician who so considers it. Brucellosis simulates so many other entities, often so exactly, that it is difficult to avoid error. Study of and reference to this excellent monograph will help to avoid this confusion.

Irving P. Borsher, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **August, 1950** **No. 8**

SOME mental reservations seem to exist, both here and in England, as to the value of mass surveys for the detection of tuberculosis in the light of the long waiting lists of patients with positive sputum. While complacency about infectious tuberculosis is shocking, yet there is great virtue in knowing the extent of the problem. The average citizen who finds that he has positive sputum is willing and ready to protect his contacts and to limit his own regimen for the betterment of his health.

A CRITICAL EVALUATION OF MASS ROENTGEN SURVEYS

Mass surveys, however, must not be viewed as the mere taking of pictures if they are to be effective in controlling tuberculosis and in uncovering pulmonary neoplasms. It must be recognized that more is needed than physical equipment, a technician, and a physician-reader. A definite philosophy is required. Because of the infectiousness of pulmonary tuberculosis and the seriousness of bronchogenic carcinoma, all photofluorograms which reveal any characteristics of either should be read as "suspect tuberculosis" and/or "suspect neoplasm".

Thus, a significant percentage of patients whose photofluorograms were read as "possible tuberculosis" should ultimately be proved nontuberculous. For instance, an area of rarefaction should be interpreted as probably advanced tuberculosis although later it is lung abscess. However, no photofluorogram read as nontuberculous basal infiltration should be found to represent active basal tuberculosis.

Similarly, when a solitary mass, atelectasis, emphysema suggesting obstruction, mediastinal enlargement, soft infiltration or cavity associated with mediastinal shift is found, the survey film should be classified as "suspect neoplasm", especially in middle-aged men. Neither film reader nor clinician should be disturbed if these lesions are subsequently found to be relatively innocuous. If bronchogenic carcinoma is ever to be conquered, it must be suspected earlier and handled as a medical emergency. Any persistent pulmonary infiltration not definitely diagnosed as tuberculous should be considered potentially malignant just as it is wise to consider all pleural effusions tuberculous until proved otherwise.

Another important aspect of survey work is the population segment to be studied. Only 0.3 per cent of 4,059 Philadelphia primary school children surveyed in 1946 were possibly tuberculous. In contrast, 8.4 per cent of 3,106 diabetic patients surveyed in 1946 and 2.3 per cent of 32,535 foodhandlers surveyed in 1947 showed possible tuberculosis. In 1948, 2.5 per cent of 20,903 Philadelphia industrial workers had a survey reading of possible tuberculosis while, for Philadelphia General Hospital admissions and outpatients, the percentage was much higher, 6.4 per cent.

It has been emphasized that only apparently healthy persons are suitable candidates for surveys. While this attitude is based on the sound premise that persons with signs or symptoms deserve more careful study than a single miniature film, the fact remains that innumerable persons with symptoms do come to survey units for photofluorograms. Many physicians hesitate to refer patients who have respiratory symptoms for careful radiologic study because of expense.

If this situation is recognized, a properly indoctrinated survey staff can surmount the obstacles presented by these persons and their physicians by inquiring about presence of cough, chest pain, and blood spitting as the film is taken. Frequently this elicits voluntary information about other pul-

monary symptoms. These data can be noted on the card so that the physician reading the photofluorograms can add to his "negative" report to the referring physician some such phrase as, "May we call attention to the fact that one miniature photofluorogram does not constitute adequate study in the presence of signs or symptoms." If such persons have no private physician, an explanation can be made of the importance of more careful studies and suitable referral made.

There are even a number of ex-sanatorium patients who have not returned to clinics or physicians for years but who come to surveys. These persons should be interviewed, impressed with the wisdom of periodic check-up and referred to a physician or chest clinic. This is a service the survey unit can undertake. The relapse rate in tuberculosis continues to be about 50 per cent.

Once the readings have been made, prompt interview of the patients with suspected disease is essential. Even an intelligent person may not go promptly to a hospital or chest specialist if the suggestion is made weeks after the taking of the photofluorogram. If a film appears to be of grave significance, the patient should be sent for at once and, if possible, hospitalized immediately. This means personal effort on the part of the survey physician. Such major decisions and vigorous action cannot be taken by clerks nor even by public health nurses. The interview with the patient whose photofluorogram is considered significant should be made *by a physician* who can explain the photofluorogram to the patient and answer questions authoritatively.

The interview must be conducted with the greatest consideration. To avoid prolonged anxiety, the appointment letter should arrive the day before the interview and should state only that the physician has set the date "to talk over the X-ray". It requires considerable experience to gauge the approach which will impress persons sufficiently to induce immediate appropriate action without disproportionate anxiety.

In the early days of the program when patients were referred to their physicians after the interview with the statement that the physician would receive a report, about 20 per cent failed to report. By the simple expedient of handing them a note on which is written their name, the name of the physician or clinic to which they are to go, the date and a brief, carefully worded report of survey findings, almost 100 per cent response was obtained. Like children, with a paper in hand to be delivered, they had some compulsion to complete the job.

Surveys are merely gestures unless adequate follow-up is an integral part of the survey program. Theoretically, once the person reaches the physician or clinic, the survey task has been completed. Some clinicians, however, fail to study survey cases adequately. Standards for follow-up examination of survey patients should include at least the taking of serial films and sputum studies, including culture. If sputum is not available and the possibility of activity is real, cultures of the gastric washings should be made. Facilities for tuberculin testing should be available.

It is the responsibility of the survey team to check on follow-up for the sake of the patient, the protection of the community, the education of the physician, and the perfection of the survey reader.

Annual roentgenograms of the chest for all adults is a feasible goal. Because bronchogenic carcinoma is found too rarely in a curable stage, it is urged that men over 45 be surveyed every six months.

A Critical Evaluation of Mass Roentgen Surveys, Katharine R. Boucot, M.D., and David A. Cooper, M.D., Philadelphia, J.A.M.A., April 22, 1950.

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Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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*Berry, N. E., and Schneiderman, C.: Vesical diverticulum, Canadian M. A. J., 58: 129 (Feb.) 1948.

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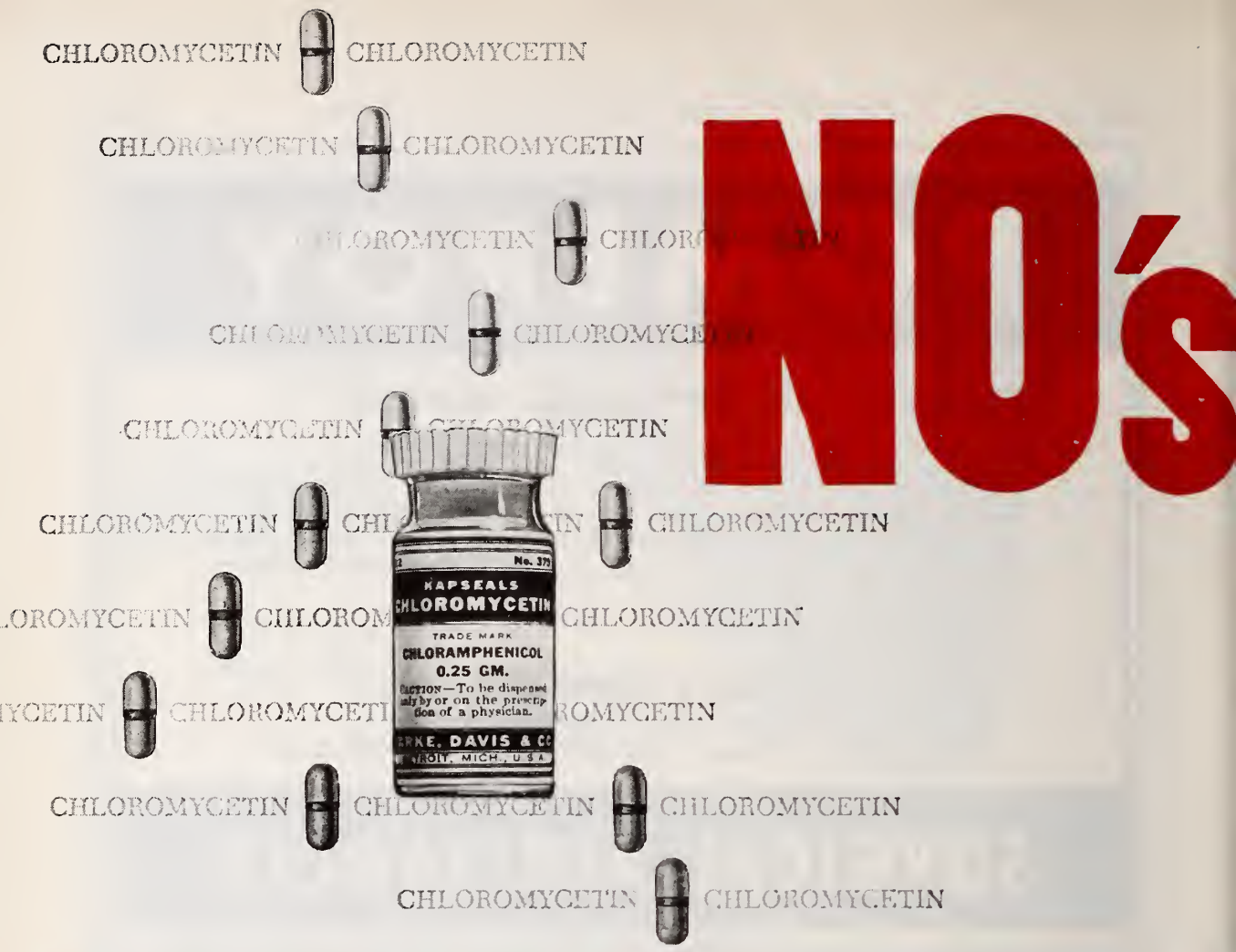

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THE OFFICIAL TRANSACTIONS

TABLE OF CONTENTS

(Alphabetical Index on Other Side)

MINUTES OF THE HOUSE OF DELEGATES — Page

Session I 3
Session II 25
Session III 26

GENERAL SESSION 45

SPECIAL ADDRESSES

Dr. Hyman P. Fine 7
Dr. Ira T. Spencer 12
Dr. James F. Norton (Retiring Address) 43
Dr. Hilton S. Read 43
Dr. Aldrich C. Crowe (Inaugural Address) 44
Dr. Louis H. Bauer 45
Dr. James F. Norton (Accent on the Positive) 47
Dr. Daniel Bergsma 50

WOMAN'S AUXILIARY

Twenty-third Annual Meeting 55
Annual Report of Treasurer 56

Issued as a Supplement to The Journal of The Medical Society of New Jersey, August, 1950

INDEX

Adult Disease Control 29, 31
Advisory Committees 29
American Legion Resolution 22, 41
Annual Meeting Committee 16, 39
Annual Meeting 1951 ..... 16, 39
Bauer, Louis H. 45
Bergsma, Daniel 50
Budget 13, 26
By-Laws Amendments 7, 10, 32
Connecticut Delegates 3
Constitutional Amendments 9, 32
Counsel for Society 6
Crippled Children Committee 30
Crowe, Aldrich C. 44
District Judicial Councils 10, 35
Dues, Annual 13, 26
Elections 25
Emergency Education Program Committee 27
Emergency Medical Services Committee 27
Emeritus Memberships 16, 41
Ethics and Discipline 10, 35
Executive Officer's Report 12, 26
Exempted Members 7, 32
Finance and Budget Committee Annual Report 13, 26
Fine, Hyman P. 7
General Practitioner's Award 6, 7, 12
General Session 45
Grievance Procedure 10, 36
Honorary Membership 16
Internship Resolution 21, 41
Judicial Council 8, 26, 32
Legislative Committee 16, 29
Medical Care of the Indigent Committee..... 30
Medical Defense and Insurance Committee Annual Report 14, 27, 32
Medical Education Committee 27
Medical Examiners, State Board of 27
Medical Practice Committee 29
Medical Service Administration 17, 27
Medical-Surgical Plan 18, 27
Military Service Committee 27
Motor Vehicle Drivers Resolution 29, 31
New Jersey Health Congress 27
New Jersey Plan Editorial 42
New Jersey Plan Resolution 7, 41
New York Delegates 3
Nominating Committee 25
Norton, James F. 43, 45, 47
Nursing Problem Resolution 21, 27
President's Inaugural Address 44
President's Report 26
President's Retiring Address 43
Public Health Committee 29
Public Health Week Resolution 7, 41
Public Relations Committee 29
Publication Committee 26
Read, Hilton S. 43
Reference Committees:
- A 26
- B 26
- C 27
- D 27
- E 29
- Constitution and By-Laws 32
- Miscellaneous Business 39
- Resolutions and Memorials 41

Resolutions 6, 21, 27, 41
Scientific Exhibit Awards 42
Scientific Exhibits Committee 39, 42
Scientific Program Committee 39
Scientific Work Committee 27
Secretary's Report 26
Spencer, Ira T. 6, 7, 12
Treasurer's Annual Report 4, 26
Trustees, Board of 5, 26
Tuberculosis Committee 17, 30
United Medical Administration Resolution... 22, 41
Veterans Liaison Committee 27
Welfare Committee 29
Woman's Auxiliary Advisory Committee..... 27
Woman's Auxiliary Resolution 6, 41
Woman's Auxiliary Transactions 55

THE MEDICAL SOCIETY OF NEW JERSEY

Tuesday Morning Session—May 23, 1950

The 184th Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, N. J., at 10:15 a. m., Dr. James F. Norton, President of the Society, presiding.

President Norton: The meeting will come to order.

In opening this 184th Annual Meeting of The Medical Society of New Jersey, I would just like to tell you now that we have a goodly bit of work to get through this morning. This is usually a long meeting. It entails the reading of many supplemental reports and the like, and if the proceedings seem a bit tedious I ask you to bear with us. I promise to do the best I can to expedite the business of the meeting and get you out of here as quickly as I can. Do we have a quorum present, Mr. Secretary?

Secretary Greifinger: Yes, sir.

President Norton: There being more than twenty member delegates from four component societies, I declare a quorum present and that we are officially prepared to transact business.

You have read the transactions of the 1949 meeting of the House of Delegates, published as a supplement to the August, 1949 Journal of The Medical Society of New Jersey. What is your pleasure, gentlemen?

Dr. Schaaf: I move they be approved as circulated.

(The motion was seconded.)

President Norton: It has been regularly moved and seconded that the minutes of the 1949 meeting be approved as published. All in favor signify by saying "Aye"; contrary minded, "No". It is so ordered.

Are the delegates from the other state societies present?

Yesterday we had the pleasure of meeting with two delegates from New York—the immediate past-president of the New York State Society, Dr. John J. Masterson of Brooklyn, who couldn't stay over. He visited us and said that he would probably be down again tomorrow. And also another past-president of the New York State Society, a very good friend of The Medical Society of New Jersey, Edward R. Cunniffe from the Bronx. They were both here and wish to be officially recorded as present.

We have also from Connecticut Dr. Oliver L. Stringfield, from Stamford, who has been coming here as a representative from Connecticut for many years. Dr. Stringfield, will you come forward and identify yourself? (Applause)

And now, as a mark of—I'll not call it my senility, but my definite senescence, I find myself in the position of welcoming here today as a delegate from Connecticut a past-resident of mine at the Hague Maternity Hospital in Jersey City, a very charming young lady who very formally is known as Dr. Katherine Quinn, but to us as Kitty Quinn. Kitty will you come forward and say hello? (Applause)

Dr. Quinn is what I call a rather charming young lady. She has a very personable personality. (Laughter)

Dr. Katherine Quinn: Thank you, Dr. Norton.

It is a distinct honor and privilege to bring the greeting of the State of Connecticut to the State of New Jersey. It is also with a sense of deep personal pleasure that I greet my former chief, Dr. Norton, under whose excellent tutelage my temporary residence in New Jersey at the Hague was a bright spot in my life. I shall bring back to Connecticut with me a report of a most profitable and a thoroughly enjoyable session. Thank you. (Applause)

President Norton: I'm glad you didn't tell them much more except about that tutelage. (Laughter) That's the trouble with bringing people up here to talk without first getting a look at their script. (Laughter) But by the same token, no one ever gets a look at mine either. (Laughter)

The report of the President is published in the May Journal on Page 206, and I have no supplemental report. It will be referred to Reference Committee "A".

The report of the Secretary is published on Page 208 of the May Journal and Dr. Greifinger has no supplemental report. By 9:50 this morning our total attendance, he tells me, was 1266. That is the highest registration we ever had at this time of the meeting.

The report of the Treasurer is on Page 207 of the May Journal. Do you have a supplemental report, Dr. Young?

Treasurer Young: Yes, sir.

(The Treasurer then read the report for the calendar year 1949 and for the fiscal year 1949-50.)

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Receipts, January 1 to December 31, 1949:	
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Journal Advertising—net	25,858.79
Commercial Exhibits at Annual Meeting	12,130.25
Interest	320.00
Sale of Maternal Welfare Books	286.00
Refund of 1947-48 Budget expenditure	1,278.53
Payroll taxes withheld from employees	5,591.42
Rents	780.00
A.M.A. special assessments	105,455.00
Refunds of 1948-49 Budget expenditures	623.34
Sale of Books	246.40
Revenue Unexpected	46.33
TOTAL	$354,849.35

EXPENDITURES (Calendar Year 1949)

Budget Accounts		$ 93,746.25
Journal Publication	$28,618.61	
Commissions	2,140.23	
		30,758.84
A.M.A. Special Assessments		104,105.00
Annual Meeting Expenses		10,673.72
Permanent Home Account		12,713.52
Journal Advertising Agent's Commission		1,772.48
Assessment Refunds—1949		145.00
Assessment Refunds—1948		20.00
Special A.M.A. Assessment Refunds		50.00
Purchase of Books for resale		228.55
Permanent Capital Fund		243.63
Budget Account Expenses for 1948-49 fiscal year		26.51
Payroll taxes withheld		5,522.94
TOTAL		$260,006.44
Cash on Hand, December 31, 1949		94,842.91
TOTAL		$354,849.35

ALLOCATION OF DECEMBER 31, 1949, CASH BALANCE

Unexpended Budget for 1949-50	$ 65,269.14
A.M.A. Special Assessments	1,300.00
Accounts Payable	521.70
Permanent Home Reserve	9,063.17
Annual Meeting Reserve	6,006.75
Special Emergency Fund	5,000.00
Total Allocated Cash	87,160.76
Surplus	7,682.15
Cash Balance, December 31, 1949	$ 94,842.91

REPORT OF TREASURER: FISCAL YEAR

RECEIPTS

Cash on hand, June 1, 1949		$141,204.97
Assessments Received:		
Atlantic County	$ 4,470	
Bergen County	12,018	
Burlington County	1,878	
Camden County	7,952	
Cape May County	1,098	
Cumberland County	2,178	
Essex County	41,106	
Gloucester County	1,542	
Hudson County	17,280	
Hunterdon County	894	
Mercer County	8,400	
Middlesex County	6,432	
Monmouth County	5,796	
Morris County	4,500	
Ocean County	1,170	
Passaic County	14,070	
Salem County	1,020	
Somerset County	2,334	
Sussex County	990	
Union County	14,382	
Warren County	1,050	
		150,560.00
A.M.A. Special Assessments		44,175.00
Journal Advertising (net)		22,707.56
Commercial Exhibits		10,965.00
Interest		309.92
Sale of Maternal Welfare Books		266.50
Accounts Receivable, 1948-49		1,047.60
Revenue Unexpected		752.33
Refund of 1948-49 budget expenditures		154.28
Refund of 1949-50 budget expenditures		1,860.64
Payroll taxes withheld		209.76
Rents		788.51
Prepaid expenses at May 31, 1949		480.00
Sale of Books		41.50
Barkhorn Fund		5.00
TOTAL RECEIPTS		$375,528.57

DISBURSEMENTS

BUDGET ACCOUNTS:	
A- 1—Executive Salaries	$ 28,290.83
A- 2—Executive Office Salaries	15,004.07
A- 3—Executive Office Expenses	2,739.53
A- 4—Executive Travel	1,543.02
A- 5—House Maintenance	5,961.23
A- 5a—Library	.....
A- 6—Treasurer	61.83
A- 6a—A.M.A. Dues Collection	407.04
A- 7—Finance and Budget Committee	47.50
A- 9—Audit	482.44
A-10—Secretary	3,432.74
A-11—Salary Taxes	618.70
A-12—Insurance	477.11
B- 2—Cuts for Journal	11.89
B- 5—Journal Office Expenses	589.29
B- 6—Journal Travel	8.69
C- 2—Welfare Committee	287.79
C- 3—Legislative Committee	1,069.97
C- 4—Public Health Committee	755.73
C- 5—Public Relations Committee	4,932.05
C- 6—Medical Practice Committee	153.11
D- 1—President	964.74

D- 2—A.M.A. Delegates	1,691.44
D- 3—Dues and Contributions	750.00
D- 4—N. J. Health Congress	80.15
D- 5—Fall Clinical Conference	1,107.65
D- 8—Woman's Auxiliary	1,995.45
D-13—Medical Education Committee	11.58
D-15—Veterans Liaison Committee	.....
E- 1—Board of Trustees	678.90
E- 2—General Contingent	1,947.95
E- 2a–Emergency Education Program	4,446.16
F- —Legal	1,276.95
H- —Pension	875.00
	$ 82,700.53
Accounts Payable, May 31, 1949	5,480.71
Annual Meeting	1,386.59
Journal Publication	24,707.41
Commissions	3,604.86
Assessments Refunded—1949	24.00
Assessments Refunded—1950	120.00
A.M.A. Special Assessments	18,350.00
Permanent Home Account	7,804.26
Permanent Capital Fund	243.63
Purchase of Books	41.60
TOTAL DISBURSEMENTS	$144,463.59
Cash Balance, May 15, 1950	231,064.98
	$375,528.57

PERMANENT CAPITAL FUND

Cash	$ 3,565.25	
Investments	11,500.00	
Balance, May 15, 1950		$ 15,065.25

ANNUAL MEETING RESERVE

Balance, June 1, 1949	$ 1,129.29	
Receipts, June 1, 1949—May 15, 1950	10,965.00	
Total		$ 12,094.29
Disbursements, June 1, 1949—May 15, 1950		1,386.59
Balance, May 15, 1950		$ 10,707.70

PERMANENT HOME RESERVE

Balance, June 1, 1949	$14,735.20	
Receipts, June 1, 1949—May 15, 1950	788.51	
Transferred from Surplus	25,000.00	
Total		$ 40,523.71
Disbursements, June 1, 1949—May 15, 1950		7,804.25
Balance, May 15, 1950		$ 32,719.45

PAYMENT OF 1949 A.M.A. ASSESSMENT

County	Members	Exempt	Obligated	Paid Number	%
Atlantic	144	..	144	135	94
Bergen	399	1	398	382	96
*Burlington	62	..	62	62	100
Camden	256	6	250	235	94
Cape May	38	..	38	29	76
Cumberland	72	3	69	64	93
Essex	1419	38	1381	1144	83
Gloucester	55	1	54	53	98
Hudson	594	..	594	585	98
*Hunterdon	31	1	30	30	100
Mercer	287	2	285	268	94
Middlesex	214	1	213	207	97
Monmouth	190	..	190	157	82.6
Morris	156	12	144	143	99
Ocean	37	..	37	36	97
Passaic	463	25	438	437	99.7
*Salem	30	..	30	30	100
Somerset	75	..	75	72	96
*Sussex	32	1	31	31	100
Union	480	4	476	360	75.6
*Warren	38	1	37	37	100
Total	5072	96	4976	4497	90
County Average					97

*One hundred per cent paid!

PRESIDENT NORTON: Thank you, Dr. Young.

The report of the Treasurer will be referred to Reference Committee "B". As Parliamentarian to function for the three meetings of the House of Delegates, I am naming Dr. Royal Schaaf.

The report of the Board of Trustees appeared on Page 208 of the May JOURNAL. The supplemental report will be presented by Dr. Lance, Secretary of the Board of Trustees.

(Dr. Lance then read the Supplemental Report of the Board of Trustees, with attached resolutions.)

BOARD OF TRUSTEES—SUPPLEMENTAL REPORT

Since the close of the published report of the Board of Trustees, two regular meetings have been held, April 16 and May 21. The following actions were taken at these meetings and are presented for your consideration and approval.

MEETING OF APRIL 16, 1950

1. A "Special Committee on Implementation of the New Jersey Plan" was appointed: Dr. James F. Norton, chairman, Dr. Royal A. Schaaf, Dr. Sigurd W. Johnsen, Dr. Harrold A. Murray.

2. Recommendations of the Publication Committee for reducing the operating deficit of the JOURNAL were approved:

(1) Increase rate for colored advertising from $25 to $40 per page.

(2) Discontinue free reprints.
(3) Increase classified advertising rate to $3 for first 25 words, and 5c for each additional word beyond 25.
(4) Over-all increase in advertising rates of 10%.

3. The Chairman of the Emergency Medical Services Committee was authorized to attend the May 6 meeting in Chicago of the American Medical Association Council on National Emergency Medical Service.

4. The Trustees authorized a permanent special committee on Medical-Surgical Plan, to consist of two representatives each from The Medical Society, Medical-Surgical Plan and Hospital Service Plan. The Medical Society representatives will be Dr. Norton and Mr. Bryan. Medical-Surgical Plan has informed the Board that Dr. Schaaf and Dr. Borsher will serve as their representatives, and Hospital Service Plan has notified the Board that their representatives will be Mr. Sorg and Mr. Durgom.

5. A request from the New Jersey Proctologic Society for the establishment of a separate section on Proctology was referred without recommendation to the Scientific Program Committee.

6. The Trustees nominated Dr. Vincent P. Butler of Jersey City for the Board of Trustees of Hospital Service Plan of New Jersey. Communication received from Hospital Service Plan stated that Dr. Butler has been unanimously elected as a member and trustee of Hospital Service Plan for the ensuing year as the Society's nominee.

7. New Jersey is now entitled to six A.M.A. delegates for 1950. Dr. James F. Norton of Jersey City was elected as the sixth delegate and Dr. L. Samuel Sica of Trenton as his alternate.

8. The Medical Education Committee was authorized to work with the Department of Defense in arranging lectures on medical aspects of atomic warfare by physicians in the state who attended a special training session at Johns Hopkins Hospital.

9. Dr. Ira Thorpe Spencer of Woodbridge, was unanimously selected by the Trustees as the recipient of the 1950 General Practitioner Award.

MEETING OF MAY 21, 1950

1. The problem of "hardship" exemptions from payment of A.M.A. dues was referred to a special committee for report back at the next meeting.

2. The State Board of Review has recently ruled that chiropractors and restricted licensed osteopaths *may* sign disability certificates for claimants for cash disability insurance. A copy of this decision has been forwarded to counsel of the Society, who will attend the next meetings of the Board, and, if desired, will advise how the ruling can be questioned upon appeal.

3. The Trustees approved the following activities of the Society's counsel on a retainer basis:

a. That counsel will attend meetings of the Board of Trustees as requested, and will also attend committee meetings and any other sessions arranged by the Society and for which his services are requested; provided that none of these meetings require his extended absence from his own office.

b. Counsel will be available for consultation with the officers or the Executive Officer on matters currently before the Society.

c. If litigation should arise involving the Medical Society, counsel's services will then be subject to special arrangement. The present retainer does *not* include services incident to the administration of the Judicial Council Plan insofar as the activities of the district councils are concerned—as contemplated in that plan.

4. The Board of Trustees authorized the incoming President, Dr. Crowe, to renew for another year the Society's contract with Veterans Administration, effective July 1, 1950.

The following resolutions were approved and referred to the House of Delegates for consideration.

RESOLUTION ON WOMAN'S AUXILIARY

The Board recommends that the resolution also be sent to the National Auxiliary.

Whereas, the Woman's Auxiliary to The Medical Society of New Jersey and its component county medical societies has rendered conspicuous service in forwarding the National Educational Campaign in New Jersey—in furtherance of voluntary action to solve medical care problems, and in opposing the threat of socialized medicine, be it

Resolved, that the House of Delegates of The Medical Society of New Jersey express its appreciation of the devoted and constructive services of the Woman's Auxiliary and, be it further

Resolved, that this House of Delegates request the Woman's Auxiliary to continue its activities in the National Educational Campaign — specifically, (1) in soliciting from lay organizations resolutions of support for our affirmative programs and of opposition to compulsory health insurance, (2) in promoting the "1-10-20 Plan" for public education on the issue of socialized medicine, and (3) in the promotion of public meetings for discussion of the Society's policies and program and the distribution of approved literature.

RESOLUTION ON "PUBLIC HEALTH WEEK"

Resolved, by the House of Delegates of The Medical Society of New Jersey, that the Society request each component county medical society to organize local observances of "Public Health Week" in the fall of 1950, and be it further

Resolved, that the Society invite the state and local health departments to join with the state and county medical societies in co-sponsoring "Public Health Week" in 1950, and be it further

Resolved, that the Society invite and request the assistance of allied professional associations and approved voluntary health organizations as co-operating agencies in the promotion of "Public Health Week".

RESOLUTION ON "THE NEW JERSEY PLAN"

Resolved, by the House of Delegates of The Medical Society of New Jersey, in annual meeting assembled on May 24, 1950, that this House affirm the interim action of the Board of Trustees in formulating and offering to the public on January 30, 1950, a statement of twelve "Proposals for a National Health and Medical Care Program", and be it further

Resolved, that this Society pledge its energies and resources to the accomplishment of this program within New Jersey, and be it further

Resolved, that the Delegates representing The Medical Society of New Jersey be authorized and directed to propose this program to the House of Delegates of the American Medical Association in June 1950.

EXEMPTED MEMBERS

The following proposal is submitted by the Monmouth County Medical Society for consideration and action of the Trustees of The Medical Society of New Jersey.

The Monmouth County Medical Society offers the following recommendation for amendment of the By-Laws of The Medical Society of New Jersey.

CHAPTER IX—FINANCE

Section 2—General Fund

(a) Annual Assessment of Members. On the first day of January. . . . for whom such payment is made. Provided however, that no assessment shall be levied against any component society for any member who is exempted by the component society from the payment of annual dues for financial reasons. Such exemptions are to be for one year only, and if it is necessary to continue exemption for a longer period, reapplication must be made to The Medical Society of New Jersey and in no case shall exemption be continued for a period longer than three years. A similar per capita assessment. . . .

President Norton: The Supplemental Report of the Board of Trustees, except the part on resolutions, will be referred to Reference Committee "A". The resolutions will be referred to the Committee on Resolutions and Memorials; and the Monmouth County Resolution is also referred to the Committee on Constitution and By-Laws.

Dr. Fine, will you bring Dr. and Mrs. Spencer to the platform, please?

(Dr. Fine escorted Dr. and Mrs. Spencer to the platform while the Delegates arose and applauded.)

President Norton: I have the pleasure, ladies and gentlement, of presenting to you Dr. Hyman P. Fine, president of the Middlesex County Medical Society, who will read to you a citation concerning Dr. Ira Thorpe Spencer of Middlesex County.

Dr. Fine: Mr. President, Members of the State Society, and Guests: Middlesex County is very proud to have Dr. Ira Thorpe Spencer chosen as the outstanding general practitioner of the year. It is a signal honor. We are all very proud and at the same time very humble to realize that Dr. Spencer is willing, able and very capable of managing his practice himself in all circumstances, at a time of life when most of you would be certainly willing to sit back and relax.

Dr. Ira Thorpe Spencer was born on July 28, 1870, in Martinsville, New Jersey, where he received his early education in public school. After attending Pennington Seminary he taught school for two years. He then attended the University of Pennsylvania, receiving his degree in medicine in 1893. After establishing his practice in Woodbridge, he married the former Anna Ensign and they have three daughters.

Dr. Spencer is active at the Rahway Memorial Hospital and was president of the staff for two years. During the first world war he was in charge of one of the medical clinics at St. Michael's Hospital in Newark. He has also been on the staff of the Perth Amboy General Hospital and is now a member of its emeritus staff.

In recognition of his work with crippled children, he was made an honorary life member of the Elks Club in Rahway.

He has also been a diligent civic worker. He is physician for Woodbridge Township, a member of the local Board of Health, and survived both Republican and Democratic administrations. He has been physician to the Middlesex County Vocational School for Girls ever since it was established a few years ago.

In the Second World War he was Chief of the Woodbridge Draft Board and Chief of Emergency Medical Service in the Civilian Defense Organization of that Township. He has been associated with the Woodbridge Chapter of the American Red Cross and at the present time is honorary vice-president. He is a member of the Exempt Volunteer Firemen's Association, and the Woodbridge Rotary Club, the American Medical Association, and the Middlesex County Medical Society, having served twice as

president of the latter organization. He is a trustee of the Woodbridge Methodist Church, so you see he hasn't overlooked any phase of the active civil and spiritual life.

His hobbies are fishing, golfing and travel. He has traveled extensively in Europe, Hawaii, and all throughout this country.

In 1944 the Middlesex County Medical Society honored Dr. Spencer and several other members who had been in active practice for more than fifty years and presented him with a fifty-year pin.

He is without doubt one of the most active practitioners we have in Middlesex County. You can call Dr. Spencer at four o'clock any morning; he will make that call. He has been practicing now fifty-seven years and I know a great many men who wouldn't answer the call after practicing seven years; he is still doing it after fifty-seven.

He also shoots an excellent game of golf. I don't know whether he still goes the eighteen holes, but he is out at the Colonia Country Club once or twice a week in good weather and plays an excellent game.

Certainly I couldn't think of a more fitting physician to be chosen as the outstanding general practitioner for New Jersey for 1950. Thank you. (Applause)

President Norton: Well, Dr. Spencer, a very interesting thing among others is your political survival rate. (Laughter) It wouldn't be so good in other communities, I'm sure. (Laughter)

But really if we had more men like Dr. Spencer willing to make night calls now and willing to hang around on the Labor Day week-end and the Fourth of July and Decoration Day and Saturdays during June, July and August, we wouldn't be in some of the bother that we are now in.

Dr. Spencer, for The Medical Society of New Jersey, not only for this House of Delegates gathered here, but for all the doctors throughout this community and more particularly for the people in Middlesex County, whom you have served so many years, I deem it a distinct pleasure and an honor to give to you this award of merit, emblematic of the distinguished practitioner of the state of New Jersey for the year of 1950. (Applause)

I am going to ask Mrs. Madden to come up and take care of the other side of the story. We have to get Mrs. Madden in the act some place.

Mrs. Madden: This really is an honor I didn't expect; but, Mrs. Spencer, these are for you. And working with the Auxiliary the way I have, I know you are just as wonderful as all the wives of the doctors that I have met, and this is an honor.

(The Delegates applauded as the bouquet was handed to Mrs. Spencer.)

President Norton: I will go back a bit to Dr. Butler. The report of the State Judicial Council appeared on Page 213 of the May Journal. Do you have a supplemental report?

Dr. Butler: Yes. You all have a copy of the Judicial Council report on your seats.

(Dr. Butler then read the Supplementary Report of the Judicial Council.)

REPORT OF THE JUDICIAL COUNCIL

The establishment of improved mechanisms by state and county societies for handling and adjusting complaints against physicians for alleged unethical or unprofessional conduct is now an official recommendation of the American Medical Association. Most of the state societies throughout the country have taken steps to modernize their machinery for the handling of grievances.

Several months ago, the Board of Trustees requested the Judicial Council of The Medical Society of New Jersey to consider ways of establishing a more adequate mechanism for this purpose within the Society. Specifically, the Judicial Council was requested to study the applicability of the "Colorado grand jury plan" to The Medical Society of New Jersey.

The Council has held four meetings devoted to this study. The Council determined that the Colorado plan, in its existing form, is not applicable to The Medical Society of New Jersey. The Council, however, has developed a plan which it herewith submits in the belief that this plan will accomplish for us all of the purposes and benefits of the Colorado plan.

The proposals here submitted contemplate that the Judicial Council of the State Society will still comprise five members, one representing each Judicial District, all of them being elected by the House of Delegates of The Medical Society of New Jersey for three-year terms.

Each State Judicial Councilor will serve as the non-voting chairman of a district judicial council within his district. Each district council will comprise two members from each of the four or five county medical societies within that district, who would be elected by their respective societies.

It is further contemplated that each county society will have a judicial committee or council of its own and it is provided that, in no case, will a member of a county judicial committee be also a member of the district council or vice versa.

Complaints from any and all sources would first be registered with the Judicial Council of the State Society. A complaint would then be referred to the district council through the chairman thereof who is a member of the State Council.

The district council will be charged with the duty of *investigating and determining all of the facts* in the case. The district council will then dispose of and close out a complaint if it finds no cause for recommending formal disciplinary action against the member concerned. The district council may attempt to settle grievances or complaints by conciliation between the two parties, and a special procedure is set forth for handling complaints concerning medical fees.

If the district council finds good cause for disciplinary action, it will then prepare a formal complaint, in consultation with legal counsel, and this complaint will be presented on behalf of the district council to the county society judicial committee. It would then be the duty of the county society committee to try the case, based upon the complaint submitted by the District Council. The county committee may then take whatever disciplinary action it may find to be indicated, subject to the by-laws of the county medical society.

If an individual member is aggrieved or dissatisfied by the action of the county society or the county society judicial committee, he may appeal to the Judicial Council of The Medical Society of New Jersey whose decision will be final, except in those cases where there still remains the possibility of a further appeal to the Judicial Council of the American Medical Association.

SUMMARY OF FUNCTIONS

The functions of the State Judicial Council under this plan are, therefore: (1) the reference of complaints to the appropriate district council; (2) general supervision of the work of the district councils and of the entire judicial system; (3) the hearing of appeals against decisions taken by the county society judicial committees.

The functions of the district council will be: (1) investigation of complaints forwarded to it by the State Judicial Council; (2) the disposition of such cases as may be disposed of without formal action being recommended to the county society; (3) the formulation and presentation of definite charges to the indicated county society judicial committee if the district council finds cause for further action.

The functions of the county society judicial committees will be: (1) the actual trial of complaints or charges forwarded to them through the district councils and, (2) the levying of disciplinary action on behalf of the county society where such action is warranted, and as may be provided by the by-laws of the county medical society.

Under this plan, a lay person complaining against a physician is assured of an objective consideration of his complaint and an adequate prosecution thereof, if a complaint appears to warrant disciplinary action. The physician is protected against the publicizing of complaints and charges since only those complaints which are found to have strong evidence of validity would ever reach the judicial committee of the county society. Matters that can be adjusted informally or by agreement between the two parties will be disposed of at the district level.

Satisfactory operation of this program requires that each county medical society have a judicial committee whose functions and procedures are clearly defined.

RECOMMENDATIONS:

1. That the House of Delegates request the Judicial Council, as its first order of business during the administrative year 1950-51, to draw up (in consultation with legal counsel) a recommended set of uniform by-laws providing for establishment of county society judicial committees. These by-laws will be proposed by the Judicial Council to several county societies.

2. That the House of Delegates officially request each county society, on receipt of the recommended uniform by-laws, to take whatever steps may be necessary to adopt such by-laws for the county society at the earliest possible date.

3. The adoption of the following amendments to the Constitution and By-Laws of The Medical Society of New Jersey; duly recognizing that the proposed amendments to the Constitution cannot become effective until one year from this time.

PROPOSED AMENDMENTS TO THE CONSTITUTION

(1) ARTICLE V—HOUSE OF DELEGATES

Delete the phrase "and shall hear appeals from the decisions of the Judicial Council,".

The amended Article will then read: "The House of Delegates shall be the *legislative* body, and shall consist of the Fellows, Officers and Delegates."

(2) ARTICLE VII—COUNCILORS

Amend this article to read as follows: "The Councilors collectively shall comprise the Judicial Council which shall be the *judicial* body of the Society. The House of Delegates shall organize five (5) councilor districts within the state. It shall elect one (1) councilor to represent each district from among the membership of each such district."

(3) ARTICLE IX—OFFICERS

Amend Section 2—"Election" (first line) now

reading: "The Officers shall be elected by this Society . . ." to read: "The Officers shall be elected by the House of Delegates. . ."

AMENDMENTS TO THE BY-LAWS

Chapter IV—House of Delegates—*Section 5, Appeals*

Delete Section 5, reading: "It shall hear and finally determine all appeals taken from decisions of the Judicial Council."

Section 6—Final Authority

Section number to become "5".

Section 7—Business During the Last Session

Section number to become "6".

Chapter VII—Judicial Council—*Section 1, Election*

Delete the last sentence, reading: "The President shall be a member of the Council ex-officio."—to bring this section into agreement with the amendment to Article VII of the Constitution.

Section 2 — Censors *(change title* to "Councilors")

Delete the present section, reading: "The Councilors collectively, shall constitute a Board of Censors of this Society known as the Judicial Council", and *substitute the following* as Section 2:

"The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of the Society."

Section 3—Meetings

Delete the present section, reading: "The Judicial Council shall meet on the evening before the annual meeting of the Society, and subsequently at the call of the chairman, or upon the petition of three of the Councilors, at such time and place as necessity or convenience requires. Four members shall constitute a quorum." and *substitute the following as Section 3:*

"The Judicial Council shall meet immediately following the election of officers for the purpose of organization. Thereafter, the Judicial Council shall meet as often as may be necessary to transact its business, at the call of the chairman. Three members shall constitute a quorum."

Section 4—Ethics and Discipline

Delete the present title of this section and substitute "Duties of the Judicial Council".

Delete the present section, reading: "All questions of an ethical nature shall be referred by the House of Delegates or the Board of Trustees without discussion to the Judicial Council. It shall consider and decide all questions of discipline affecting the conduct of members. It shall consider all questions involving the rights of members, whether in relation to each other, to component societies, or to this Society. It shall also consider complaints of lay groups or persons against members of this Society." and *substitute the following:*

"The duties of the Judicial Council shall be as follows:

"(1) To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other Board or Committee of the Society.

"(2) To adjudicate all disputes or controversies arising within The Medical Society of New Jersey.

"(3) To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate district judicial council, to be established as hereinafter provided and, in general, to supervise the activity of the several district judicial councils in the interest of assuring prompt and equitable handling of all such matters brought to the attention of the Society.

"(4) To receive, consider and rule on any matter of discipline concerning any member or members of the Society brought to the Judicial Council on appeal from a county judicial council or equivalent body of a county medical society."

Present *Section* "5"—Appeals, to be changed to "Section 10" and the following new Sections 5, 6, 7, 8, and 9 to be added.

Section 5—District Judicial Councils ....

"There shall be a district judicial council in each Judicial District in the State, to be known as a 'district council'. Each district council shall consist of two members elected by each component county medical society within the district, together with the Judicial Councilor elected by the House of Delegates of The Medical Society of New Jersey to represent the district. Each elected member, except the chairman, shall serve a term of two years, the term of one member representing each county society terminating on May 31 each year. No member shall be eligible to serve simultaneously as a member of a district council and of a county society judicial committee. A quorum of a district council shall consist of five members, exclusive of the Judicial Councilor, and action shall be taken by majority vote of those present.

"The Judicial Councilor shall serve as the chairman of the district council in his district. He shall be generally responsible to the Judicial Council for the administration of the affairs of the district council. He shall render a report at each meeting of the Judicial Council relative to the work of the district council over which he presides. Such report shall include a record of the disposition of all complaints or other matters referred to or considered by the district council. He shall have voice but shall not vote in the deliberations of the district council.

"Each district council shall also elect from among its members a secretary, and a vice-chairman who, in the absence of the chairman, shall perform the duties of the chairman."

Section 6—Procedure for Considering Grievances

"Any complaint, allegation or grievance concerning a member of the Society, when received by the Judicial Council, shall be referred to the Judicial Councilor from the district in which the physician complained against maintains membership. Thereafter the Judicial Councilor shall present the matter at the earliest opportunity to the district council of which he is the chairman.

"Upon receipt of such a complaint, allegation or grievance, the district council shall make such investigation as may be required to determine all the relevant facts and circumstances. Such investigation shall be conducted in a strictly confidential

manner, and in accordance with rules of procedure to be established by the Judicial Council.

"If, after careful investigation, the district council shall find no cause for recommending disciplinary action against the physician or physicians involved in a particular complaint, the case shall be closed and a report of such disposition shall be made to both parties and, through the chairman, to the Judicial Council.

"If the district council finds that a given complaint, allegation or grievance can be settled by conference and conciliation between or among the parties, or if the district council shall determine that the interests of the parties involved will be best served by the rendering of private advice to the physician in question, then the case shall be considered closed and a report of such disposition shall be made to both parties and to the Judicial Council.

"If, after careful investigation, the district council finds that there is *prima facie* evidence warranting disciplinary action, it, in consultation with the Society's legal counsel, shall prepare or cause to be prepared a formal written complaint against the accused. The district council shall then present or refer such complaint to the judicial committee of the county medical society of which the accused is a member, for appropriate action by such county judicial committee.

"If the district council shall find that a complaint, allegation or grievance involves a matter which would empower the State Board of Medical Examiners to revoke or suspend a practitioner's license, it shall be the duty of the district council forthwith, by written complaint, to refer the case to the Judicial Council which shall, in turn, refer the complaint to the State Board of Medical Examiners."

Section 7—Functions of County Judicial Committees

"Upon receipt of a formal complaint from the district council, the county society judicial committee shall hear and try the matter in accordance with its by-laws and established rules of order. If the county judicial committee shall determine that disciplinary action is warranted against the accused, it shall take such action in accordance with the by-laws of the county medical society. A report of such action shall be filed with the Judicial Council."

Section 8—Administration and Procedure

"The administrative and legal costs of the operation of the Judicial Council and of the district councils shall be underwritten by The Medical Society of New Jersey in accordance with an annual appropriation for these purposes to be approved by the House of Delegates.

"Every matter coming before a district council shall be considered in a strictly confidential manner. The records of the district council shall be maintained under the supervision of the Judicial Councilor for that district, and shall be subject to inspection exclusively by members of that Council and by legal counsel for the Society. Except for purposes of consultation or testimony as required by the district council, no member or officer of the Society shall be present at a meeting of a district council when any complaint is under consideration.

"In pursuance of its investigatory and judicial functions, district councils shall have authority to summon members of the Society to appear and testify, either in connection with a complaint involving the member summoned, or as witnesses in cases involving other members. If any member fails to respond to such a summons, the district council shall be, and hereby is, authorized to cite such a member to his component society for contempt. Such a citation shall be considered equivalent to a charge of unethical conduct and shall take the course provided in Section 7.

"The Judicial Council shall make and publish rules and regulations for the conduct of investigations, the disposition of cases, and the formulation of formal complaints by the several district councils. Such rules shall specify periods of notice, procedure for disposition of complaints against physicians who are not members of the Society, procedures for notification of complaints and defendants, maintenance of proper records and other pertinent regulations."

Section 9—Special Procedure for Complaints Involving Fees for Professional Services

"In a complaint involving the just or proper amount of a fee for professional services, the district council shall first investigate and attempt to effect an amicable settlement. If the district council be unable to reconcile the differences, then it may determine the fee which it considers just and proper under all the circumstances of the particular case. If the Society member against whom the complaint is brought agrees to abide by the decision of the district council and shall register this agreement with the patient in a form to be prescribed for this purpose, then the case shall be considered closed and only an impersonal statistical report shall be rendered by the chairman to the Judicial Council.

"If the member agrees to the amount of the fee so fixed but fails to abide by his agreement, then the district council may cite such a member for contempt and so notify the judicial committee of his county medical society for appropriate action.

"If a member fails to accept such a determination in the first instance, such action may, in the discretion of the district council, constitute grounds for the preferring of formal charges by the district council to the county society judicial committee."

Present Section 5—"Appeals" changed to Section 10.

This section to be amended to read as follows:

"*Section 10*—Appeals

"Any member of a component county society aggrieved by an action of the county judicial committee, or any applicant for membership who has been excluded from membership by a county society, or any lay person aggrieved by an action of the county society judicial committee may appeal from the decision or action of the county society or the county judicial committee to the Judicial Council.

"Decision of the said Judicial Council in any matter so appealed shall be final, except that fur-

ther appeal may be taken by either party to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

"Any appeal to the Judicial Council of The Medical Society of New Jersey must be filed with the Judicial Council within 45 days of the date of the formal notice to the aggrieved party of the action of the component society or of the county society judicial committee.

"Form of notice of appeal and procedure in hearing and adjudication of same shall be in accordance with rules of procedure to be established by the Judicial Council, which shall be made available to the parties involved.

"Upon filing a notice of appeal, the appellant and the component society or county society judicial committee will be required to submit to the Judicial Council all records and papers relative to the matter under appeal. All such papers shall be treated confidentially by the Judicial Council.

"The Judicial Council may affirm, modify or reverse, by a majority vote of its members present and voting, the appealed decision. The Judicial Councilor presiding as chairman of the district council shall not be eligible to sit on any appeal taken to the Judicial Council as herein provided. The Judicial Council may summon witnesses, take new evidence and investigate the appealed matter, in any manner required to develop the information necessary for a proper decision.

"Until such time as the Constitution, Article V, shall be amended to remove from the House of Dedegates the function of hearing appeals from the decisions of the Judicial Council, such appeals shall be heard and adjudicated by the House of Delegates, rather than by the Judicial Council of the American Medical Association. Upon the approval of such amendment to the Constitution, this paragraph shall be stricken from the By-Laws."

President Norton: Thank you, Dr. Butler. This supplemental report will be referred to the Committee on Constitution and By-Laws.

Now, I don't know anything that is of more importance than the matter embraced in this revision of the chapter concerning the Judicial Council. From the report, I am sure you get some idea of the amount of work that has gone into the preparation of this.

Those of you who would like to be heard on the matter may appear before the Reference Committee, tonight, on Constitution and By-Laws and there discuss the controversial points of this program rather than have the thing come in here tomorrow and have so many divergent opinions concerning it. Again, I emphasize that we recognize what the whole problem is and it is to meet a demand of the public that we do something about setting our own house in order; it has been a very difficult piece of work and I am sure you will appreciate it.

I will ask Dr. Spencer now to say a few words to the House of Delegates. (Applause)

Dr. Ira Thorpe Spencer: Dr. Norton, Dr. Fine, and House of Delegates of the State Society; I certainly wouldn't want to go away from here without thanking you for this honor you have conferred upon me. I hope that I shall have the pleasure of continuing to practice medicine for some more years and I shall look back at this as one of the happiest occasions of my life. And I want to thank you for the compliment that you have given Mrs. Spencer. Thank you. (Applause)

President Norton: The individual Judicial Councilors inform me that they have no supplementary reports. The report of the Judicial Council as printed in the Journal will be referred to Reference Commttee "A".

Report of the Executive Officer was published in the May Journal on Page 214, and Mr. Bryan has a supplemental report.

Mr. James E. Bryan: Mr. President, Members of the House of Delegates: I have a very brief report and this is probably the only thing during the past year that I have done without checking in advance with my boss, the President, and I am quite sure that had I checked it with him he would have knocked me down or in some way made it impossible for me to have this opportunty to say what I want to tell you.

In my work as Executive Officer from year to year, it is one of my privileges to work very closely with the President and to serve him in attempting to put into effect the administrative program and the policies that he and you have determined shall be done. In that capacity perhaps I have a closer and more complete and adequate appreciation of what a President does for a medical society and the time he devotes to the work of the medical society than almost anyone else could possibly have.

I don't think that the record of this meeting, gentlemen, would be complete if some statement were not made of the enormous amount of peregrination that your President, Dr. Norton, has done during the past year in carrying the banner for medicine into the camp of the enemy as well as the camp of many of our friends.

I have yet to ask him to take a speaking engagement that he has turned down, and he has become, of course, rather meritedly, a well-known public speaker. Demand for his services in that respect during the past year has been tremendous.

I feel that some record should be made of the fact that—I don't know how many meetings he has attended—his secretary has no complete record of it and he has no complete record of it and neither have I—but I daresay it is three or four times a week perhaps in many weeks, and something, I think, should have been said about this; and therefore I took it upon myself, without previous consultation with our President, to say that.

Other than that, I just want to express for myself the appreciation I have for the work of all of our staff in the Society. It goes without saying that nothing that we, who happen to stand out and have a chance to speak to you at various times, do, could have been done were it not for the devoted, unsung and loyal service on the part of our entire staff, and I take this opportunity to express my appreciation to all of them.

Finally, I want to thank the members of the House of Delegates for the privilege of having worked with you another year. (Applause)

President Norton: The original report of the Executive Secretary as published in the May Journal will be referred to Reference Committee "A".

The report of the Finance and Budget Committee was published on Page 216 of the May Journal. Is there a supplemental report from Dr. Allman?

Dr. Allman: There is, Mr. President. I do not want you to get fooled by our Treasurer when he tells you that his cash balance as of May 15th was $231,064.98. He has that much money, or thinks he has. (Laughter) Like money in our wives' bank account, it may be our money, but we can't spend it. And Dr. Young has called your attention to the fact that much of that money was earmarked, and I am going to tell you just how much is earmarked and how it is earmarked.

For the A.M.A. 1949 assessment, the Treasurer is holding $1350. The 1950 A.M.A. dues collected so far total $27,425.

In the Permanent Home Reserve Fund there is $32,719; and in the Annual Meeting Reserve is $10,707. We have $15,000 set away in our Retirement Pension Reserve; and we have Accounts Payable of $209. There is a Special Emergency Reserve Fund of $10,000; and we have Budget Accounts to carry us to the end of this fiscal year, which will amount to approximately $18,000. Out of the $231,000 we must set aside about $84,000 to carry us over for the other seven-twelfths of the year. So that actually while the Treasurer properly reports a cash balance of over $230,000, only some $32,000 of it is real spendable money; and I don't think that that is much of a reserve or much cash at the end of a year for an organization doing a quarter of a million dollars' worth of business a year. Your Committee has approved of and the Trustees have approved the Committee's recommendation of the following budget.

MAY 21, 1950
BUDGET — 1950-51
(As approved by the Board of Trustees, April 16, 1950)

A- 1—Executive Salaries	$ 29,000
A- 2—Executive Office Salaries	18,900
A- 3—Executive Office Expenses	2,000
A- 4—Executive Travel	2,250
A- 5—House Maintenance	6,400
A- 5a–Library	100
A- 6—Treasurer	250
A- 7—Finance and Budget Committee	250
A- 9—Audit	500
A-10—Secretary	3,000
A-11—Salary Taxes	900
A-12—Insurance	1,440
B- 1—Journal Publication	5,000
B- 2—Cuts	100
B- 5—Journal Office Expenses	500
B- 6—Journal Travel	200
C- 2—Welfare Committee	1,000
C- 3—Legislative Committee	4,000
C- 4—Public Health Committee	1,600
C- 5—Public Relations Committee	5,000
C- 6—Medical Practice Committee	1,300
D- 1—President	3,000
D- 2—A.M.A. Delegates	5,600
D- 3—Dues and Contributions	1,700
D- 4—New Jersey Health Congress	250
D- 8—Woman's Auxiliary	3,300
D-13—Medical Education Committee	100
D-16—Membership News Letter	2,500
D-17—Public Health Week	500
E- 1—Board of Trustees	1,000
E- 2—Contingent	15,000
E- 3—Emergency Education Committee	5,000
F- —Legal	3,000
Total	$124,640

Last year, the assessment was $30 per member. By simple arithmetic you can easily arrive at the fact that with approximately 5000 members in order to raise that much money we must divide it. So $25 per member for 5000 members would bring us in $125,000, and we need $124,640. The Committee therefore recommends that the assessment of this year be reduced from $30 to $25. (Applause)

President Norton: The report of Dr. All-

man—again that looks like simple business reading that thing off, but I want to assure you that a tremendous amount of work goes into this material before it comes in here. It took Dr. Allman a matter of five minutes to read that report, but it took a long, long time to get it together and to effect the reduction that he spoke of.

The report will be referred to Reference Committee "B".

The Publication Committee Report was published in the Journal on Page 217. There is no supplemental report.

The Medical Defense and Insurance Committee Report was published on Page 218 of the May Journal. Supplemental report by Dr. Hurff.

Dr. Hurff: Dr. Norton, Members of the House of Delegates: I believe you all have in your possession copies of this report, *Professional Liability Insurance.*

(Dr. Hurff then read the supplemental report.)

MEDICAL DEFENSE AND INSURANCE

J. Wallace Hurff, M.D., Newark, Chairman

Professional Liability Insurance

The number of members now insured under the special professional liability contract of The Medical Society is 4037, which tops all previous records. The steady growth in the number insured indicates the value of this specialized protection.

We are however, deeply concerned with the marked increase in the claims reported by the insurance company during the past year, reaching a high of 103, against 59 for the preceding year. This condition is general throughout the state. Listing them by counties we find the following: Atlantic 1, Bergen 6, Camden 1, Cumberland 2, Essex 27, Hudson 20, Mercer 3, Middlesex 4, Monmouth 11, Morris 2, Ocean 2, Passaic 12, Sussex 1 and Union 10.

Claims can be summarized under the following headings: x-ray burns 6; diathermy burns 7; other burns 6; spinal anesthesia 3; injections 9; fractures 11; electric shock 3; broken needles 2; improper treatment 3; improper diagnosis 2; tonsil operations 3; radium 1; transfusion 3; foreign bodies 11; teeth broken by instruments 6; property damage 3; miscellaneous 24.

With the view of securing a reduction of claims within the specialized practice groups (such as x-ray and radium) the Committee has recognized the importance of the patients' signing the special forms prepared by the insurance company's defense attorney. These forms are available to those practitioners and their use is recommended as they have been found effective; in fact, results have already been produced. The Committee has under consideration the use of suitable forms for spinal anesthesia and physiotherapy should claims from these groups continue materially to affect our loss ratio.

The insurance company is still carrying reserves on cases reported prior to March 1st, 1949, in the amount of $81,000 and $49,250 on the past year's claims totaling $130,250 in reserves to date. The company paid out on cases settled during the past year (including legal expenses) $91,869.89. The Committee has given consideration to the abnormal loss situation as presented by the insurance company and they urge the cooperation of members to exercise the greatest vigilance in conducting their practice in order that the number of claims may be reduced to a minimum. Frequently claims are presented in which there is no malpractice or negligence. The reluctance of the physician to defend himself (calling upon the company to settle cases to avoid suits which could be won if tried) is a considerable factor in the loss ratio. Should there be any doubt in this respect the Committee is always available for conference to advise any member as to whether a suit should be settled or permitted to go to trial. It may be expedient to settle small claims, but we call your attention to the fact that substantial settlements definitely increase our loss ratio.

No change will be made in the prevailing schedule of premiums at the present time. The company hopes that next year may show an improvement in the loss situation.

There is a present trend to bring suits jointly, where the doctor and one or more of his employees are held individually liable. The Committee deems it advisable, therefore, to clarify the extent and limitations of your professional liability contract. This was thoroughly discussed in letters printed in our Journal and in all county *Bulletins.* Since there is still misunderstanding we now reiterate our published statement.

Here is what your policy provides: The doctor is covered for all acts of his own and for nurses, assistants, technicians, et cetera, for which he is individually chargeable, arising under the various captions of coverage set forth in his policy. He is covered for his and his assistants' acts and has full protection in the amounts for which he is covered under those captions set forth. But if a suit is brought not only against the doctor but against one or more of his employed assistants, technicians, nurses, et cetera, the latter are *not* insured against their personal liability. How can these employees be protected for their personal liability? The company has agreed to provide a separate policy in the name of the employees in accordance with the following schedule of rates:

Lab. Technician, 20 per cent of the ordinary practitioner's rate.

Physiotherapists, 50 per cent.

X-ray Technician, diagnostic work only, 50 per cent.

X-ray Technician giving treatments, 100 per cent of the x-ray rate.

Blood technicians, 25 per cent of the basic physician's rate.

Graduate or registered nurses, 20 per cent.

Our official broker, Faulhaber & Heard, Inc., is

prepared to secure protection for your employees and will furnish the necessary applications for the coverage. It is optional as to whether the premium cost is paid by the doctor or by the employee. The rate will be the same. Throughout the year, your committee has been active in reviewing exceptional cases, assisting the insurance company in obtaining expert witnesses and securing professional information necessary for defense.

ACCIDENT AND HEALTH INSURANCE

Our accident and health insurance policy with the National Casualty Company has again been improved by the Company during the past year.

On November 23, 1949, we were surprised by E. & W. Blanksteen of Jersey City (our accident and health insurance brokers) who announced that the National Casualty Company had agreed to extend the sickness coverage of our policy from a limit of twelve months for any one sickness to twenty-four months for any one sickness *at no additional cost*. In previous years, when this matter was discussed with our brokers we were informed that such additional coverage would cost 12½ per cent additional premium. Through the efforts of the Blanksteen Agency, this coverage was extended to us at no additional cost, due to a very large spread of this type of business on the part of our agency and the company.

It is fitting that we should comment at this time on the forward progress of our accident and health insurance plan through the years as a result of the close cooperation of your committee on medical defense and insurance with our accident and health insurance agents and the National Casualty Company. Twenty years ago our policy was limited to benefits for one year of accident and one year of sickness on a "house-confining" basis with acceptance of renewals exclusively at the option of the Company. Policies were issued on a highly selective basis at that time and many applications were rejected. Gradually our policy was developed on a group basis with the individual policies not being cancelled by the Company and renewal of policies refused only if the doctor gave up the practice of medicine or discontinued his membership in the society.

Coverage was then extended as experience developed, from one year for accident to two years, then to four years, and then to five years. The insuring clause changed from "external, violent and accidental means" to "accidental bodily injury", the broadest insuring clause available in the United States. The sickness clause was extended from one year (originally on a "house-confining" basis) to two years where it is today, with full benefits payable *regardless of house confinement*.

Although we have an age limit of 65 for the acceptance of risks, once a policy is issued it is renewable for the doctor regardless of age, so long as he continues in active practice and remains a member of the society.

While the coverage was being increased, rates were reduced on two or three occasions. Last rate reduction was in 1942, in the face of rising costs of operation. Today about 2800 of our members hold a policy with the National Casualty Company, at a cost per policy considerably below cost of comparable individual policies obtainable on the open market.

In 1948 the company again conducted an open enrollment permitting uninsurable members to join the group, limiting impaired and uninsurable risks to policies of $200 a month regardless of medical or insurance histories. We hope to make arrangements for another open enrollment with the company to take place, perhaps at the close of this year or early in 1951. Insurable risks may always apply for a policy by writing to E. & W. Blanksteen, our brokers, whose full page advertisement appears on the inside front cover of our Journal.

Highlight of our policy, in addition to its liberal insuring clauses, is the arbitration provision which provides that any disagreement in claim benefits may be submitted for arbitration to your committee on medical defense and insurance, who are the *sole* arbiters. During the past year, 298 members filed claims for benefits ranging from $6.66 (the lowest paid claim) to $4800 for the highest amount paid. During the past year, as well as in several previous years, no claim was referred to your committee for arbitration.

Our agent has announced that he has secured the company's approval for the extension of the overall disability coverage from our present maximum limits of $400 a month to $500 or $600 monthly. This will make it possible to increase the average of the group on impaired risks from $200 to $300 monthly indemnity.

RECOMMENDATIONS

1. The committee is deeply conscious of the fact that its members must serve for a considerable period of time before they become conversant with the many intricate problems relative to insurance. We therefore, recommend to the House of Delegates that the committee be increased from five to seven members, urging that the two additional appointees be young men, who with years of experience will be better able to perpetuate the work of the Committee.

2. There is a marked increase in the number of residents, interns and other employed physicians who are not eligible for our medical defense insurance because they are not members of any county society. These doctors are vulnerable to suits and should be protected. We recommend that our Society communicate with the New Jersey State Hospital Association, explaining the situation and urge that these doctors be covered with some form of protection.

3. The committee recommends the approval of the professional liability contract with the United States Fidelity & Guaranty Company, through Faulhaber & Heard, Inc.; and the accident and health policy with the National Casualty Company, through the E. & W. Blanksteen Agency and that they be renewed for the ensuing year. Both these companies have excellent financial rating being classified in the Alfred M. Best Financial Reporting Agency as A-1.

President Norton: Thank you, Dr. Hurff.

This report of Dr. Hurff, together with his original report, will be referred to Reference Committee "D", except that part of the recommendation which deals with the increase of membership from five to seven. It is now so determined by the By-Laws that it shall be five, and I will refer the first recommendation to the Committee on Constitution and By-Laws.

The Committee on Scientific Work has no supplemental report and their original report as published in the Journal is referred to Reference Committee "D". Dr. Hamilton has no supplemental report for the Woman's Auxiliary Advisory Committee. The Chair is going to rule now that any other supplemental report or any future supplemental report of which you now have a copy in your hands will be read by title and the mimeographed sheet shall constitute the publication of the report, and that, with the report will be referred to the Reference Committee.

We will now hear a supplemental report from the Honorary Membership Committee. Dr. Londrigan.

Dr. Londrigan: (Dr. Londrigan then read the supplemental report of the Honorary Membership Committee.)

COMMITTEE ON HONORARY MEMBERSHIP

Supplemental Report

Additional Recommendation for Emeritus Membership in The Medical Society of New Jersey—Passaic County recommends Dr. Hiram Williams, Montclair, age 81, retired because of age—Member in good standing of county medical society since 1911.

President Norton: Dr. Londrigan's report will be referred to the Committee on Resolutions and Memorials. The report of the Medical Education Committee appears on Page 220 of the May Journal. There is no supplemental report. It will be referred to Reference Committee "D".

The Annual Meeting Committee. Dr. Harrold A. Murray.

Dr. Murray: Our Committee recommends that the next meeting be held at Haddon Hall on Monday, Tuesday and Wednesday, May 14, 15 and 16, 1951.

President Norton: It will be referred to the Committee on Miscellaneous Business. The Scientific Program Committee has no supplemental report. The original report as published will be referred to the Reference Committee on Miscellaneous Business.

The Scientific Exhibit Committee has no supplemental report. The report as published in the May Journal will be referred to the Reference Committee on Miscellaneous Business. The Welfare Committee has no supplemental report. Its original report as published in the May Journal will be referred to Reference Committee "E".

Subcommittee on Legislation; Dr. Blaisdell.

Dr. Blaisdell: Dr. Londrigan will make that report, Mr. President.

Dr. Londrigan: No adverse legislation was passed in this recent session of the Legislature which adjourns *sine die* on Wednesday. Towards the end of the session, an article appeared in one of the newspapers. It said that any legislation disapproved by The Medical Society of New Jersey would be handicapped, and that it would take a great deal to overcome that objection. We did disapprove of about eight or ten bills that never did get out of committee. When one was placed on the table, it was immediately removed when it was found out that we disapproved of it.

I want to congratulate the keymen who were called upon by telephone, telegraph or other ways to communicate with their assemblymen or senators, and to apprise them of our opinions of a certain bill. Everybody gave cooperation. I want to thank the committee on Legislation for their work. They have done a splendid job.

One particular bill, which we opposed, was A-168, the Chiropractic Bill, and a great deal of pressure was brought to bear upon the legislators. If you understand what pressure means, and you can analyze it, you know the answer.

That is the Subcommittee's report, Mr. President.

President Norton: That is the report of the freshman, the Executive Secretary of the Legislative Committee. And I suppose when he said no adverse legislation came to a vote on the floor, I think we have something to be thankful for.

Need I tell you that my good friend, Dr. Londrigan has a very, not too subtle and surely not too oblique method of stimulating what we might call euphemistically "public relations". If you don't know what I mean, I feel sorry for you. But he did very well. His expense account might be a little up down there —but I think I'd better go on.

The next item is the Subcommittee on Medical Practice. Dr. Herschel S. Murphy has no supplemental report. The report as published in the May Journal will be referred to Reference Committee "E".

The report of Dr. Londrigan on Legislation

will also be referred to Reference Committee "E". The Subcommittee on Public Health, Dr. Samuel Blaugrund, chairman, informs me that they have no supplementary report. The report as published in the May Journal, on Page 225, will be referred to Reference Committee "E".

Subcommittee on Public Relations; Dr. Luke A. Mulligan. Dr. Mulligan is absent, but I know he has no supplemental report, and his report will be referred to Reference Committee "E".

(President Norton then read the list of Advisory Committees to the Subcommittee on Public Health.)

REPORT OF THE TUBERCULOSIS ADVISORY COMMITTEE

The Tuberculosis Advisory Committee held a special meeting on April 30, to give Dr. Paul K. Bornstein, chairman of the chest committee of Monmouth County Medical Society, an opportunity to present plans for improving the x-ray service for clinic patients in that county.

This is to consist of an arrangement with three more hospitals making a total of four institutions that will provide more frequent and convenient opportunities for diagnostic films. Dr. Bornstein pointed out that routine high school surveys were expensive and revealed a steadily decreasing incidence of cases. His committee felt therefore that the money spent for these surveys could be devoted to paying the cost of x-raying clinic patients by the local hospitals. However, high school surveys were paid for by Board of Education appropriations which could not be diverted for other purposes. The plan to extend clinic x-ray services by Monmouth County through three more hospitals met with unanimous approval of our Committee. The Monmouth County committee was commended for its efforts in that direction and for its interest in adding chest films as a routine procedure for all hospital and clinic patients.

Dr. Hughes brought up the question of following the plan of New York State in providing state aid to all hospitals willing to take chest films as a routine admission practice.

The question of discontinuing high school surveys was discussed. Most of those present were opposed to the idea. Dr. Eisenhower pointed out that the surveys were at least as valuable as dental care, if not more so.

Dr. Newcomb reported that the incidence of tuberculin-positive students was higher than the patch test (10%) would indicate for groups tested intradermally gave 18 per cent positive reaction.

Dr. Hughes reported that x-ray units were being planned for cardiac clinics. This would likely result in overlapping of services.

Dr. Hatch emphasized the pressing problem of tuberculosis in hospitals for mental disease.

The status of BCG was taken up. After the conclusions and recommendations of the U. S. Public Health Service were read, it was unanimously agreed that the vaccine was not sufficiently standardized nor stable enough for general distribution and use.

President Norton: Hearing no additional reports, the reports of all those Advisory Committees as printed in the Journal are hereby referred to Reference Committee "E".

(President Norton then read the list of Advisory Committees to the Subcommittee on Medical Practice.)

President Norton: There being no supplemental reports, the reports of the Advisory Committees to the Subcommittee on Medical Practice are referred to Reference Committee "E". The report of the Emergency Medical Services Committee as published in the Journal will go to Reference Committee "C". Dr. Alexander's Military Service Committee has no supplemental report. The report as published in the May Journal will be referred to Reference Committee "C", as will the report of the Veterans Liaison Committee. Nor is there any additional report from the Emergency Education Committee. That too is referred to Reference Committee "C".

As for the Medical Service Administration, there was no report in the May Journal. Dr. Schaaf will now report on Medical Service Administration and on the Medical-Surgical Plan of New Jersey.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

1. During 1949 the activities of Medical Service Administration have been limited to the operation of the City of Newark Medical Plan.

2. This Plan, designed to meet the needs of the indigent and medically indigent of the City of Newark, a reimbursement plan rather than an insurance plan, provides payment on a fee for service basis for services rendered by physicians of the patients' choice for care of eligible persons confined to their homes by illnesses.

3. The Plan continues to be a successful demonstration of the cooperation of an official health agency with a voluntary agency controlled by the medical profession in solving the problem of medical care of the indigent and medically indigent. It continues to arouse nation-wide interest as a pioneer effort to solve this problem within the framework and approved principles of organized medicine.

4. The following Table depicts the experience of the Plan over a six year period, showing actual costs and reflecting the changing economic picture. In interpreting this Table we remind you that the "indigent" are those whose names appear on the welfare rolls of Newark and that the "medically indigent" are those who, in the opinion of the Social Service Bureau of the City Board of Health (while having sufficient income to meet the routine cost of a satisfactory standard of living) do not have sufficient income to pay for adequate medical care.

Indigent (Relief) Persons	1944	1945	1946*	1947	1948	1949
Mean number of persons on welfare rolls during year.....	2082	1719	2155	2995	4274	7986
Value of Approved Services....	$2,243.00	$2,607.50	$4,971.00	$7,823.00	$8,589.50	$12,046.00
Cost per capita of Relief Load—per year.....	1.07	1.51	2.30	2.61	2.00	1.51
per month.....	0.089	0.126	0.191	0.217	0.167	0.126
Medically Indigent Cases†						
Number of Cases during year...	435	1575	2950	2734	3283	4155
Value of Approved Services....	$1,260.00	$3,659.50	$9,556.50	$10,633.50	$12,775.50	$15,119.50
Cost per Case per year.....	2.89	2.32	3.23	3.89	3.89	3.639
Cost per Case per month.....	0.240	0.193	0.269	0.324	0.324	0.303

Since the only fixed, or well defined group, are the "indigent", the cost per capita in this report is limited to the indigent group. It is impossible to estimate the size of the "medically indigent" population. As presented below the figures pertaining to the "medically indigent" load consist only of those medically indigent persons classified as "medically indigent" when requesting medical services, hence their costs are depicted on a cost *per case* basis rather than on a *per capita* basis.

The Plan has operated very smoothly in this past year. The relief load has increased approximately 87 per cent over that of 1948 and the claims for relief cases have increased approximately 40 per cent over last year. The cost per capita of relief load has decreased from $2.00 per year in 1948 to $1.51 per year in 1949.

Medical care of the indigent and medically indigent under a plan like the City of Newark Plan meets with the hearty approval of patients, physicians and governmental agencies. The standard of medical care is higher and the costs to the government are less than under other systems. The greatest financial saving is due to the fact that under such a Plan many people are cared for at home and a less number of people are hospitalized.

DR. SCHAAF: You have been handed the report of the Medical Service Administration of New Jersey. I present it first because it is overlooked most frequently in the minds of our members. Its importance and its significance are not generally appreciated.

I will not go into the detailed items which appear on the report, but I would like to remind you that the Medical Service Administration is a separate and distinct corporation from the Medical-Surgical Plan. Its purpose primarily is to develop ways of taking care of the indigent and medically indigent; in other words, to effect the distribution of medical care among this group. This is still our most pressing problem in our effort to establish a national health program within the present framework of medical practice. We should all be aware of the importance of it. At present its only function is to operate the Newark Plan. This Plan is significant because it has provided a pattern for the medical care of the indigent and the medically indigent which can be put into operation in any community in the state and which is a feasible method of bringing medical care to the indigent and medically indigent people of the country. It should be fostered and developed.

Along with the Medical Service Administration, Mr. Chairman, I would like to present, with the consent of Dr. Aldrich Crowe, Chairman *pro tem* of the Board of Trustees of this meeting, the following memorandum or letter:

"DEAR DR. CROWE: The Board of Governors of the Medical Service Administration of New Jersey resubmits the following nominees for membership on the Board of Governors of the Medical Service Administration of New Jersey: The nominees are: Harry N. Comando, Samuel A. Cosgrove, William F. Costello, Sigurd W. Johnsen, Elton Lance, George W. Merck, Royal A. Schaaf, Edward W. Sprague and John S. Thompson.

Mr. Chairman, I move that the report of the Medical Service Administration of the nominations be referred to the appropriate Reference Committee.

We will now go on to the subject of the Medical-Surgical Plan, and I will call your attention to this voluminous report which is now in your hands in mimeographed form.

Mimeographed copies of the report were distributed to all in attendance. Additional copies are available on request to Dr. Irving P. Borsher, Medical Director, Medical-Surgical Plan, 790 Broad St., Newark, N. J.

A catastrophe overtook the Plan abruptly on the morning of March 30 when Dr. Scott expired suddenly almost instantly and left the Plan without his guidance and experience.

* In April 1946 fees payable physicians were increased from $2 per day visit and $3 per night call to $3 and $5 respectively.

† The word "case" means family as distinguished from "persons" referred to under report on "indigent".

Fortunately we had an assistant medical director in the person of Dr. Irvin P. Borsher, who had been with Dr. Scott for two years and who had acquired a complete knowledge and mastery of the technic of the Plan, and he was able to carry on. In the week or two immediately following Dr. Scott's death there was chaos in the office until Dr. Borsher had it reorganized, and this report, while it represents actual writing and compilation by Dr. Borsher, is based on accumulated data which Dr. Scott had prepared in readiness for submission to this House of Delegates. He simply had not had time to write the report, and until the deadline for the Journal had passed, Dr. Borsher had not time to complete it. In this report you have an account of the Medical-Surgical activities up to May 17, the date at which it was finally passed upon by myself and by our counsel as representing an accurate statement of the activities of the board and of the Medical-Surgical Plan during the past year.

The report is complete, it is informative, and it will answer many of the questions which have come to the minds of individual participating physicians. I urge all of you to read it carefully.

Our Board and our Medical Director and our new Assistant Medical Director are prepared at all times to answer questions and we welcome requests for information. Many of the uncertainties and indecisions that you may have in regard to the activities of the Board, the provisions of our contract and so on can be easily elucidated by a telephone call or a letter. You will always receive courteous consideration and an answer which will be an answer and not an equivocation.

We think we can answer almost any problem, any question that is brought up, and if we can't give you the answer we will change our mechanism so that we will remove the disability of which you may complain.

So, along with this report, I offer a similar letter from Medical-Surgical Plan to Dr. Crowe and with the request to him that it be transmitted directly to the House of Delegates, nominating the following personnel for membership on the Board of Trustees of the Medical-Surgical Plan for the ensuing year.

"Dear Doctor Crowe: The Board of Trustees of the Medical-Surgical Plan of New Jersey respectfully submits to the Board of Trustees of The Medical Society of New Jersey for transmission to the House of Delegates of that body the following nominations for election to the Board of Trustees of the Medical-Surgical Plan of New Jersey: Lewis W. Brown, Harry N. Comando, Samuel A. Cosgrove, William F. Costello, William E. Dodd, Sigurd W. Johnsen, Elton W. Lance, Royal A. Schaaf, Rudolph C. Schretzmann, Reuben Sharp, Edward W. Sprague and John S. Thompson.

At this point, Mr. Chairman, I would like to point up rather briefly, but I hope effectively, some of the things which have happened in the past year in the Medical-Surgical Plan.

I will steal a phrase of Dr. Norton's and say that *de jure* the Medical-Surgical Plan is a separate and distinct corporation from The Medical Society of New Jersey, but *de facto* it is an integral part of The Medical Society of New Jersey. It is your baby. We hope we have nourished it well and that it is prospering according to your wishes and your hopes.

At the meeting of the House of Delegates last year the Trustees of the Plan were directed to develop an individual policy which we could offer on a direct enrollment basis to the public in the effort to secure a much wider spread of voluntary insurance coverage than we then had.

Our enrollment increased 113,000 since the session last year. That is not up to what we had hoped, but in view of the many difficulties which we encountered in the development of the individual policy we hope that you will bear with us, because on the 15th of May 180,000 individual subscribers in the Hospital Plan were offered an opportunity to enroll in the Medical-Surgical Plan on an individual basis. Those 180,000 subscribers represent approximately 300,000 persons. They are a select group; they are a seasoned group; they are people who appreciate the value of hospital insurance coverage on an individual basis; and we expect to get from them a very large proportion, at least fifty per cent, which will immediately augment our enrollment tremendously.

The enrollment is presently in progress and it will terminate on May 29. Mr. Sorg will be here this afternoon and we may have some preliminary hint as to the popularity of this policy with the general public.

I would like at this point to pay a special tribute to certain representatives from the Hudson County Medical Society. The individual policy is the result of the, shall I say not gentle prodding but insistent prodding of our President, who at the beginning of his administration stated that success in opposing a compulsory system of insurance in this country depended upon the dissemination of voluntary coverage on the widest possible basis. He was insistent from the beginning that we develop this individual policy, and subsequently,

maternity coverage was added to it. Our Board felt that it was very risky from an actuarial standpoint and that it could not be done safely; however, with the again ungentle and insistent prodding of Dr. Norton we studied it most carefully and came up with a radical departure in the matter of voluntary sickness insurance. In the policy which has just gone forth we are offering to the public for the first time increased maternity coverage not only for hospital care but for home and office care. It is not the amount of money which we will pay an individual doctor for these direct enrollment cases, it is only sixty per cent of the amount of benefits which we will pay for maternity in the group enrollments; but we hope that is temporary. We hope to hold in escrow enough money in excess of the sixty per cent so that we may prorate it and refund it to the doctors from whom it has been withheld. We have precedent for that action.

When the Plan started in 1942 we set up a schedule of benefits which we hoped to be able to pay. We did not know whether our actuarial computations were sound, but for six months we ran on an experimental basis, paying eighty per cent of the promised benefits. At the end of six months we found that we could pay the full benefits and we then refunded the full amount to the physicians from whom we withheld twenty per cent of the payments. At this moment the Medical-Surgical Plan has paid every penny which has ever been pledged to be paid.

There are some additional actuarial risks in this new policy. After it is in operation we may not find it feasible to continue it on its present basis. It may have to be modified a little here and a little there. But it is a tremendous forward step in the distribution of medical care on a voluntary sickness and insurance basis. And I would like especially to commend Dr. Norton, Dr. Donnelly and the other members from Hudson County, who insisted upon the inclusion of this benefit in the policy.

If Dr. Norton irked any of our Board during the course of these deliberations, it was done for a good purpose. None of us resented it. I think that, in effect, he gave us a kick in the pants and brought about for the benefit of the people of New Jersey a very forward-looking policy. This afternoon, I note that Dr. Norton is going to talk to you about the New Jersey Plan, which colloquially is now known as the Norton Plan. We hope it will be nationally known as the Norton Plan; certainly it will be known as the New Jersey Plan. I would like to tell you how that plan evolved.

Dr. Norton felt that adequate use of the potentialities of the Medical-Surgical Plan for gaining goodwill of the public and for providing voluntary sickness insurance care had not been adequately utilized. He felt that the Medical-Surgical Plan, the Hospital Plan, and The Medical Society of New Jersey should work as a unit in developing an acceptable program. We have had endless conferences, by telephone, in person, formal meetings and informal meetings, and as a result of the deliberations of this group, again spearheaded by Dr. Norton, we evolved the "New Jersey Plan". It was launched at a press conference at the end of January. At that time we had representatives of the press from the most important papers in the United States, including the New York *Times,* the New York *Tribune,* the Newark *News*, the Philadelphia *Bulletin,* and many others. Dr. Norton presented this Plan and immediately it was seized upon with enthusiasm by the press. We received favorable publicity beyond the wildest dreams of any of us who participated in the development of the program. We had favorable comments from as far away as Spokane, Washington. We had favorable comments from religious journals, political bodies, labor unions, and newspapers. We have assembled for presentation to the American Medical Association a review of all of the favorable publicity which we received, and that is quite a thick brochure. The reporters were very keen about it. They said: "this is a very fine presentation; it is a forward-looking program". The Newark *News* said editorially: "it is thinking far beyond anything which has emanated from the American Medical Association to date, but what are you going to do to implement it?"

Well, after all, there are certain things that one has to do to implement it. You have to carry out your pledge to distribute voluntary insurance to provide for the indigent and medically indigent, adequately to staff depleted areas with medical personnel and so on.

There is not an item in this which can properly be said to be socialistic or would tend to foster or develop a program of socialized medicine, in our meaning of the term, in this country. We presented it to the American Medical Association. I am personally disappointed at the reception which the Plan received at the top level of the American Medical Association. We were entitled to a sixth delegate in December, and the Board of Trustees chose to nominate Dr. Norton to go to San Francisco and to present this Plan, as being the man best fitted to expound it. Certainly he

knows it better than the rest of us; he is largely responsible for its development, and it has brought to New Jersey a tremendous amount of recognition from individual state and county societies and from other organizations outside of medicine, and you have something here of which you can be very proud.

I'd like to add just a final word which is a personal tribute to Dr. Norton. I have been working with him very closely during the past year. I don't know whether he had been with me or on me or at me, but we have been together more than a little. I have been to many meetings where he has spoken. Certainly the Society has been beautifully represented with the lay groups.

Last winter he invited me to go to a certain meeting because he wanted me to be able to answer certain specific questions about voluntary sickness insurance as offered by the Medical-Surgical Plan. I went to the meeting. It was a cold night in January; and we were warned that it was a very unfriendly group. It consisted of 250 school teachers constituting the Schoolmasters' League of New Jersey. Dr. Norton addressed this group, knowing that they were antagonistic, and he spoke on the positive approach. He delivered a magnificent address to those people for forty-five minutes. He held them spellbound. At the end of the meeting they gave him a tremendous hand.

There were three or four needlers there and with great tact and diplomacy he demolished them, just as he disemboweled Mike Davis in Montclair.

We have had a magnificent champion in Dr. Norton and I personally would like to express my gratitude and appreciation for his contribution to the Society in the past year. (Applause)

President Norton: Thank you, Dr. Schaaf.

I'm prodding, now, they call it. Well, we have had a lot of fun anyhow.

The reports of the Medical-Surgical Plan and the Medical Service Administration will both be referred to Reference Committee "C".

The next item is the New Jersey Health Congress, whose report appeared on Page 242 of the May Journal. Is there a supplemental report, Dr. Blaisdell? There is none. Then the report as printed will be referred to Reference Committee "D". On page 241 of the May Journal, you will find the report of the State Board of Medical Examiners. Is there a supplemental report, Dr. Hallinger? There is none. Then the report as published will be referred to Reference Committee "D".

Are there any resolutions to be presented?

Dr. Kreutz: I have one.

President Norton: The Chair recognizes the doctor from Union.

Dr. Kreutz: At a meeting of the Executive Committee of the Union County Medical Society on April 10, 1950, the following resolution was recommended to the county society.

Whereas: All or many hospitals find it increasingly more difficult every year to procure adequate complements of interns; and

Whereas: Hospitals associated with teaching institutions have more interns than are necessary to fulfill their need; and

Whereas: Some hospitals associated with teaching institutions have during the past year increased their quota one hundred per cent; and

Whereas: A continuation of the present trend, which is now evident, to place increasing numbers of interns in hospitals associated with teaching institutions, will eventually deprive the small community and rural hospitals of the necessary interns to care for the sick of their community. Therefore be it

Resolved: That the Union County Medical Society respectfully solicit The Medical Society of New Jersey to request the delegates to the A.M.A. to present to the House of Delegates at the A.M.A. convention in San Francisco in June, 1950, a resolution directing the A.M.A. to make internships a two (2) year rotating or straight internship or one year rotating and one year straight internship; and be it further resolved,

That interns be alloted to approved hospitals on the basis of bed capacity of said hospital or the number of admissions per year or both so that all hospitals approved by the A.M.A. may receive a sufficient number of interns to expediently and efficiently provide the proper care required for the sick.

President Norton: This will be referred to the Committee on Resolutions. The whole problem of intern training and allocation of interns and approval of hospitals for intern training will be a very hot issue, in the San Francisco meeting. There is a special committee of the House of Delegates of the American Medical Association now studying the problem and the Chairman of the committee is our own Dr. Londrigan. So we will be all right.

Dr. Burritt: This also is a resolution sent to the House of Delegates by the Union County Medical Society, with a preamble which is explanatory of the resolution.

For some years now, a country-wide shortage of nurses has made itself apparent and this is growing worse. This shortage seems to be brought about by four factors working together: (1) increasing hospital population; (2) high wages for young women of the professional and even unpro-

fessional status; (3) increasing employment of nurses by the federal government and public health agencies; (4) the laudable raising of the standards of both pre-nursing and nurses' training.

It would further appear that (although it is not the sole factor) at least a major cause of inability to fill the classes of existing training schools, lies in the increased requirements and the strictness of enforcement of those requirements, before and during training. Many applicants are rejected by training schools because they may lack, in their pre-training high school studies some one required academic course. These required courses might even be included in training.

Bed-side nursing care of patients is the greatest desire of most prospective nurses. Flexible application of purely discretionary regulations is the most easily varied factor in making it less difficult for prospective nurses to attain their desired—not to say inspired end. It would seem wise, therefore, to reconsider the over-all value, to the professions and to the public, of enforcing the desirable high standards, by allowing a little flexibility in the application of the regulations concerning those standards. Looking toward producing an increased number of nurses for complete bed-side care of the seriously ill patient, we would therefore, offer the following resolution:

Whereas: The maintenance of an adequate supply of properly trained personnel is one of the great concerns of The Medical Society of New Jersey, and

Whereas: The maintenance of high standards of nurses' training is necessary with the present scientific progress of medical sciences, and

Whereas: There has been a recent decrease in the numbers registered in the nurses' training classes, together with the closing of a number of nurses' training schools due to inability to fill the classes because, in part at least, of the stringent application of the rules of high standards, be it therefore—

Resolved: That the House of Delegates of The Medical Society of New Jersey express its concern over the situation as it exists and request a survey of the effects of the rigid application of standards of qualification, both before and during training, to determine if some formula can be worked out whereby those inspired young women who wish to study nursing, can accomplish their purpose in a manner that will not be found so burdensome as to make it impossible for hospitals to maintain nurses' training schools, in the face of present inadequate numbers of nursing teachers and nurses' teaching facilities, and be it also

Resolved: That to serve the purpose of this resolution, the officers of The Medical Society of New Jersey request conference and study between the officers of the New Jersey Registered Nurse Association and the members of the New Jersey Board of Nurses Registration and the members of the Nursing Advisory Committee of The Medical Society of New Jersey and any appropriate committee of the New Jersey Hospital Association and any appropriate authorized members of the New Jersey State Board of Health, and any five laymembers from the public whom the governor might wish to appoint to serve the purposes of this investigation; and that a report be made to the Governor, to the Board of Trustees and to the Welfare Committee of The Medical Society of New Jersey, before the end of 1950.

President Norton: I am going to refer it to Reference Committee "D".

Are there any other resolutions? Do you have a resolution?

Secretary Greifinger: Yes. I am reading this resolution at the request of Physicians Post Number 445 of the American Legion.

Physicians' Post of the American Legion asks that our Society join them in condemning the proposed creation of a new monster medical agency, a federal "United Medical Administration". They state that:

"This new gigantic medical agency will tie up into one single package all of the medical services to 14 million veterans, 2 million military personnel, countless USPHS beneficiaries, and presumably to the wives and children of army and navy personnel too. What this will lead to should be obvious to any alert medical society." They offer the following resolution together wth an explanatory memorandum:

Whereas there has been introduced into the U. S. Senate bill S.2008 which provides for a "United Medical Service" consolidating all medical and hospital activities of the Veterans Administration, Public Health Service, Army and Navy into a single gigantic medical agency; and

Whereas this bill would substantially deprive the VA, the Army and Navy of control over their own hospitals; and

Whereas the professional personnel of the federal government would, in the course of this transfer, lose their present security and be at the mercy of a politically appointed administrator; and

Whereas for the reasons indicated in the memorandum below, such a law would make for inefficiency, insecurity and mounting expense,

Therefore Be It Resolved that we strongly oppose S.2008 as an unneeded piece of legislation which will impair medical care of veterans, and

Be It Further Resolved that we call on our representatives in the United States Congress to vote against this bill and that a copy of these resolutions be spread on the minutes sent to our Senators and Representatives in

Congress and to the principal newspapers of New Jersey.

Senate bill S.2008 has in it numerous defects which would make it undesirable to see S.2008 enacted into law. It is felt, for reasons below indicated, that this legislation would (a) impair the efficiency and quality of medical and hospital care to veterans, and (b) weaken morale among medical personnel in the VA, Army, and Navy. Reasons in support of this conclusion follow. Page references are to the Senate print of this bill.

1. In blunt language the bill states: "The Department of Medicine and Surgery of the Veterans Administration is abolished". Sec. 9a; page 16, lines 12-13.

It is generally conceded that this department has brought to veterans a quality of medical care second to none. Why should it be abolished?

2. The Administrator of the proposed United Medical Administration (UMA) is instructed (Sec. 3a; page 3, lines 8 to 13) to consult with a board at least once a month "with regard to policies and proposed policies". This board includes representatives of the VA, the Army, the Air Force and the Navy, each having one voice.

Obviously the active military personnel will outvote the VA representatives 3 to 1 on matters of policy, yet VA beneficiaries will account for 80 per cent of the patients treated by UMA. One can scarcely expect an equitable voice for the veterans by this arrangement.

3. All VA hospitals are taken away from the VA (Sec. 4a2; page 4, line 3).

This cannot possibly improve service. On the contrary, it separates the eligibility-determining and bed-finding functions completely. The VA could certify a veteran as eligible but would be helpless to find him a bed, assure him of an admission date, or exercise any kind of control over his hospital stay. Where hospital observation is needed for examination, insurance or pension purposes, the VA would depend on the courtesy of an outside agency (the UMA) to furnish the necessary data. The examinations would be done by men totally unfamiliar with VA requirements.

4. The efficient out-patient clinics, now the pride of every VA Regional Office, are destroyed. Section 4a2 takes from the VA "all facilities of the VA for outpatient services to veterans". This can mean only one of three things. (1) Either new clinics will be set up by the UMA at different locations; or (2) Veterans will be referred to city dispensaries for the care of service-connected cases; or (3) Private physicians will be paid fees for treatment of these veterans. The latter procedure, while not undesirable, would be fantastically expensive—unnecessarily so in view of the current smoothness of operation of VA clinics. To set up new UMA clinics is scarcely a step in the direction of efficiency. And these new clinics, divorced from all VA control, can hardly operate as adequately as do the present VA clinics, in the processing of claims. The remaining possibility — reference of service-connected veterans to city dispensaries—is indefensible.

5. Personnel now employed in the Department of Medicine and Surgery of the VA will be handled as follows: "Any personnel which the Administrator of the UMA shall find to be in excess shall be separated from the service". (Line 21 of page 6, section 4c of the bill). This gives the Administrator the right to take away any physician's job at will; he is accountable to no one for his action, since his finding that the doctor is excess is—under this bill—sufficient to separate him.

The ghastly effect of this on the morale of the physician should be obvious and the point need not be further labored.

6. The pay of physicians is disposed of in this clause: "Rules promulgated by the President . . . shall supersede existing laws fixing the rates of pay . . ." (Lines 15 to 21 of page 11, section 6a). Presumably the President would delegate this authority to high officials of the proposed UMA.

The undesirability of this is obvious.

It may be pointed out that the bill has a certain air of plausibility about it which will attract many citizens who will not analyze it clause by clause. On the face of it, it seems desirable and efficient to consolidate all medical functions into a single agency. It is therefore appropriate that we make some comment as to this background.

a. Net effect of this bill is to create a new agency. This means new officials, new overhead organization, new quarters and space, new supplies, et cetera. Experience shows that you do not save money by creating a new agency. The savings effected by the consolidation are illusory because the Army, Navy, Federal Security Agency and VA will remain as government agencies and they have many overlapping medical functions. For example, physicians will still remain on VA rating boards and at Army station hospitals under control of the VA and Army respectively. Thus there will be duplication rather than consolidation.

b. The public has been led to believe that federal hospital construction is more costly than construction of hospitals by private agencies, and this is hailed as one of the reasons for this reform. The truth is: (1) That whether the federal hospitals are built by the VA or by the UMA they will still be built by branches of the federal government; (2) Most VA hospitals are constructed for chronic patients and it is grossly misleading to compare them with hospitals for short-term care; and (3) Government hospitals necessarily include space for recreational, administrative, housing, finance and similar units which are not needed in private hospitals, and most of the excess cost is in these areas.

c. The allegedly longer hospital stay in federal hospitals than in private institutions is also advanced as a reason for the change. Since the UMA hospitals will still be government institutions, it is hard to follow the logic of this. In any event, the allegedly longer stay is due to the fact that it is customary to hospitalize patients under VA or Army control for the preliminary work-up as well as for the post-operative or post-treatment convalescence. This is not done in private hospitals where the practice is to have the work-up done on the outside, admit a patient the evening before

an operation and send him home in a week. The way the government does it is medically more sound, but if reforms here are desired, it can be effected by a simple administrative rule; it scarcely needs a brand new agency.

d. The Commission on Organization of the Executive Branch (popularly known as the Hoover Commission) has recommended dismembering the VA into several parts. It would assign insurance functions, home loan functions and medical functions to three other agencies. This is recommended because the VA is now considered too huge an agency to be efficient. It is respectfully suggested that the same reasoning should apply to such huge organizations as General Motors. And note that in curing the defect, the suggestion is to create several new agencies (insurance company and UMA) although administrative common sense indicates that you do not promote efficiency by breaking down functions and reassigning them to separate agencies. Ironically, the crime of size is not considered applicable to medicine. Here the cure is to create not only a new agency, but a great big one.

President Norton: I will refer it to the Committee on Resolutions.

Are there any other resolutions? Are there any memorials? Any amendments to the Constitution and By-Laws? (No response)

Does any member of the House wish to be heard on any new business? (No response)

The present By-Laws stipulate that an amendment to the By-Laws must be read twice before it is referred to a Reference Committee and before it can be acted upon in the same annual meeting.

The report of the Judicial Council was read by Dr. Butler. It is a document of eight pages, of which you all have a copy. It has been read in full once. Will you rule as to whether we can read it by title?

Dr. Schaaf: The Parliamentarian rules, Mr. Chairman, that the presentation of the proposed changes in the By-Laws in regard to the Judical Council do constitute the second reading at the time of the final convocation of this body.

President Norton: Dr Butler, will you make that motion?

Dr. Butler: Thank you, Dr. Schaaf. I am sure we are very pleased with your decision.

In order that we will conform with the By-Laws, I move that the first reading stand as one reading and that the printed amendments as are presented to the Delegates here will satisfy the demands of the By-Laws as the second reading.

Will that be adequate?

Dr. Schaaf: Yes.

Dr. Butler: I so move.

President Norton: Will some one move that we have unanimous consent of the House?

(Motion was made and seconded.)

President Norton: It has been regularly moved and seconded that we have unanimous consent of the House to proceed in the manner indicated, and that the reference by title, by Dr. Butler, of the report of the Judicial Council shall serve as the second reading, and you all have a copy of the report. All in favor; contrary minded. So ordered.

Dr. Lance: May we follow the same procedure with the alteration in the By-Laws that I read, entitled Chapter 9, Finance? Can that be handled in the same way? It is very brief.

President Norton: Will the Parliamentarian rule?

Dr. Schaaf: I would rule, Mr. Chairman, that this amendment, because of its brevity, actually be re-read.

President Norton: All right.

(The amendment was re-read.)

I urge all the members and their friends to visit the exhibits and to register so that exhibitors will have concrete evidence of our interest.

I would just like to ask the counsel for the Medical-Surgical Plan and the Hospital Service Plan of New Jersey, who just came in the room, with whom I conferred many times during the year and whom I prodded not too infrequently but I am sure in the best of manner, Mr. Sorg to let the group see that nothing material has happened to him. (Applause)

I would ask Dr. Borsher, who is the new Medical Director of the Medical-Surgical Plan of New Jersey, he succeeds the late Dr. Scott, just to stand and identify himself. (Applause)

Is there any new business? (No response)

We meet at 2 P. M. The Chair now is ready to entertain a motion to adjourn until 2 P. M.

(Upon motion duly made by Dr. Londrigan, seconded and carried, the meeting was adjourned at 12:25 P.M.)

Wednesday Noon Session — May 24, 1950

The meeting convened at 12:10 p. m., President Norton presiding.

President Norton: The Chair recognizes Dr. J. Howard Hornberger, who will make the report for the Nominating Committee.

Dr. Hornberger: Mr. President and Members of the House of Delegates: The Nominating Committee of the State Society met on Monday evening at eight-thirty in accordance with the provisions in the Constitution and By-Laws. There were representatives from each of the twenty-one counties present. All credentials were certified as being correct by the Secretary. We will therefore proceed to give you the report of the Nominating Committee as concluded at its meeting as of that date.

As you all know, of course, the President-Elect of the State Society, currently Dr. Aldrich C. Crowe, automatically steps up to the presidency without election. Therefore, the first office to have been considered by the Nominating Committee was for the office of President-Elect for a one year term ending in May 1951. Unless otherwise specified, all of these nominees will be for that same period.

The Nominating Committee presents to this House of Delegates for the office of President-Elect for this one year term the name of Dr. Sigurd W. Johnsen.

For the First Vice-President of this Society for the same term, Dr. Harrold A. Murray.

The Nominating Committee then offered the following candidates:

Office	*Term Expiring*	*Nominee*
President-Elect	May 1951	Sigurd W. Johnsen
First Vice-President	May 1951	Harrold A. Murray
Second Vice-President	May 1951	Henry B. Decker
Secretary	May 1951	Marcus H. Greifinger
Treasurer	May 1951	George J. Young
Trustees:		
First District	May 1953	William F. Costello
Second District	May 1953	Joseph G. Coleman
Third District	May 1953	William C. Wilentz
Fifth District	May 1953	David B. Allman
Councilors:		
Second District	May 1953	Vincent P. Butler
Fifth District	May 1953	Chester I. Ulmer
A.M.A. Delegates and Alternates:		
Delegate	December 31, 1950	Elmer P. Weigel
Alternate	December 31, 1950	Herschel Pettit
Delegate	December 31, 1950	James F. Norton
Alternate	December 31, 1950	L. Samuel Sica
Delegate	December 31, 1952	J. Wallace Hurff
Alternate	December 31, 1952	John H. Rowland
Delegate	December 31, 1952	David B. Allman
Alternate	December 31, 1952	Frank W. Konzelmann
Delegate	December 31, 1952	Elmer P. Weigel
Alternate	December 31, 1952	Herschel Pettit
Delegate	December 31, 1952	James F. Norton
Alternate	December 31, 1952	L. Samuel Sica

Delegate and Alternates to Other States
(Terms Expire May 31, 1951)

Delegate to New York: Aldrich C. Crowe
Alternate to New York: D. Ward Scanlan
Delegate to Connecticut: C. Byron Blaisdell
Alternate to Connecticut: Blackwell Sawyer

Standing Committees:

Committee	*Term Expires*	*Candidate*
Finance & Budget	May 31, 1956	Luke A. Mulligan
Publication	May 31, 1951	J. L. Evans, Jr.
Publication	May 31, 1953	R. M. L. Buchanan
Scientific Work	May 31, 1955	William W. Maver

The name of each candidate was presented individually. The Chair called for nominations from the floor after each presentation. No nominations were offered for any office. Motion was, for each office, then made to close nominations and to instruct the Secretary to cast the unanimous ballot of the House for the candidate. This motion, in each case, was passed. Accordingly the candidates listed above were each declared elected.

There being no further business, on motion, the House recessed at 12:37 p. m.

Wednesday Afternoon Session—May 24, 1950

The House convened at 2:15 p. m., President Norton presiding.

President Norton: The House will come to order. The first item on the agenda for the afternoon's program is the Report of Reference Committee "A", by Dr. Echikson.

(Dr. Echikson then read Section (1) of the Report of Reference Committee "A".)

Dr. Echikson: Mr. President, I move the approval and the adoption of the President's report.

(The motion was seconded and carried.)

(Dr. Echikson then read the remainder of the report, which was adopted, section by section, upon motions regularly made, seconded and carried.)

REFERENCE COMMITTEE "A"

Reference Committee "A" reviewed carefully the report of the President.

(1) We note with much satisfaction the enormous amount of time and effort expended in the performance of his duties by the President. We wish to commend him for a job especially well done.

The Committee wishes to call to the attention of this body the high esteem in which The Medical Society of New Jersey is now held throughout the nation, which is due, in great part, to the foresight and progressive thinking, the tenacity of purpose and the soundness of the President's ideals. These ideals should become the basis of the philosophy of the medical profession on a national level. We have been particularly fortunate in having as our President such an outstanding thinker.

(2) Our Executive Officer, Mr. James E. Bryan, has done an exceptional job in public relations. The report fails adequately to portray the great amount of time and effort spent in carrying our message not only to the component county medical societies, but also to lay people wherever he felt his presence could further our cause. His energy is boundless and we are indeed indebted to him for an excellent performance in his field.

(3) The Committee has studied with much interest the report of the Secretary. We note the high degree of accomplishment and the efficiency with which the work was performed. We realize that while much of this work was routine, its completion was facilitated by not only the time and attention devoted to it by Dr. Greifinger, but was also made possible only by the highly efficient and well-organized staff, working under the very capable and indefatigable Executive Assistant, Mrs. Madden. The teamwork manifested by this group is a model to be emulated by all other levels of activity in our organization.

(4) The Judicial Council should be congratulated for its effort and vision in approaching a solution to a problem which has long commanded our attention. The Supplemental Report will be reviewed by another committee.

(5) The Board of Trustees has effectively reviewed and acted upon all matters brought to its attention. The work has been monumental and their work is well done.

President Norton: Thank you very much, Dr. Echikson. Reference Committee "B" has for consideration the reports of the Treasurer, the Finance and Budget Committee and the Publication Committee. That report will be made by Dr. F. Clyde Bowers of Morris County.

(Dr. Bowers read the report of Reference Committee "B", which was adopted, section by section, upon motions regularly made, seconded and carried.)

Dr. Bowers: I move the adoption of the report as a whole.

(The motion was seconded and carried.)

REFERENCE COMMITTEE "B"

Reference Committee "B" met on May 23rd, and reviewed the report of the Publication Committee as printed in the May Journal. The Committee approved the report *in toto* without any comment.

It also reviewed the report of the Treasurer as printed in the Journal and his supplementary report as presented to the House of Delegates. Dr. Young was present at our meeting and went over the items as listed. The Committee was satisfied with the report and they approved it.

The report of the Finance and Budget Committee was also received, including the supplementary report as presented to the House of Delegates. This was reviewed with the help of Dr. Allman who was present at our meeting and gave invaluable assistance in reviewing each item. The Committee concluded that the budget of $124,640 was satisfactory.

It also approved the 1951 assessment of $25 per capita.

No member of the Society appeared before Reference Committee "B" with any complaint or comment.

President Norton: Next item is the re-

port of Reference Committee "C", which has for its consideration the Medical Service Administration, the Medical-Surgical Plan, the Emergency Medical Services Committee, the Veterans Liaison Committee, the Military Service Committee, and the Emergency Education Program Committee.

(Dr. Weber read the report of Reference Committee "C", which was adopted upon motion regularly made, seconded and carried.)

REFERENCE COMMITTEE "C"

Reference Committee "C", met on May 23. The Committee considered the report of:

1. The Medical Service Administration.
2. The Medical-Surgical Plan.
3. The Emergency Medical Services Committee.
4. The Veterans Liaison Committee.
5. The Military Service Committee.
6. The Emergency Education Program Committee.

The reports were gone over in minute detail and carefully considered. All the reports are approved and it is recommended that they be accepted without any changes.

PRESIDENT NORTON: Reference Committee "D", has for its consideration the reports of the Medical Education Committee, the Scientific Work Committee, the Medical Defense and Insurance Committee, the Advisory Committee to the Woman's Auxiliary, the State Board of Medical Examiners, and the New Jersey Health Congress; the report to be made by Dr. Frederic W. Lathrop from Union County.

(Dr. Lathrop read the report of Reference Committee "D", which was adopted, section by section, upon motions duly made, seconded and carried.)

REFERENCE COMMITTEE "D"

Reference Committee "D" approved the report of the Medical Education Committee and commends their activities.

We approve the report of the Scientific Work Committee.

We approve the report of the Committee on Medical Defense and Insurance. We urge a campaign of education on the details of insurance available to the doctors, such education to be carried on through the *News Letter*.

We approve the report of the Advisory Committee to the Woman's Auxiliary and congratulate the ladies for taking such a positive stand against the advocates of compulsory health insurance.

We approve the report of the State Board of Medical Examiners of New Jersey.

We approve the report and the activities of the New Jersey Health Congress and join with them in mouring the loss of Dr. Stanley Nichols.

In reference to the resolution concerning the nursing situation, the Committee agrees that something needs to be done and offers the following resolution:

Inasmuch as the registered nursing personnel is not sufficient to render adequate service to the sick, and

Inasmuch as the practical nursing training program has been rendered ineffective, it is

RESOLVED, that The Medical Society of New Jersey request the Governor of New Jersey to appoint a fact finding committee to study the entire nursing situation, including both the registered nurse and the practical nurse training programs; such committee to consist of lay individuals familiar with the educational problems involved; and to report both to the Governor and to the Board of Trustees of The Medical Society of New Jersey before the end of 1950.

I move the adoption of that resolution.

(The motion was seconded.)

PRESIDENT NORTON: You have heard the resolution. It has been regularly moved and seconded. Is there a discussion?

DR. MORRIS (Union County): Does a Reference Committee have a right to introduce a resolution at this time?

PRESIDENT NORTON: I am going to rule that they have not. It's modifying the report that was sent to them.

DR. MORRIS: I would amend the motion to the effect that it be referred to the Board of Trustees for consideration.

PRESIDENT NORTON: Well, I am going to rule that it is a part of the report of this Reference Committee and in doing so I am doing it only because I would like the House of Delegates to pass upon it rather than sending it back to the Board of Trustees. I would like to have the primacy of the House of Delegates recognized and established, and I am going to rule—

DR. MORRIS: My motion wasn't seconded, so I will withdraw it.

PRESIDENT NORTON: The original motion of Dr. Lathrop's is now before the House.

DR. LANCE: Mr. President, a resolution of this type has many implications. It suggests that lay persons be asked to give advice upon a situation whch is ninety per cent medical. Resolutions like that should be subject to study by the House of Delegates before they are asked to pass upon it, having heard it read for the first time.

DR. LATHROP: We introduced this request

to the Governor because, at the present time, the nursing situation is more or less at an impasse. At the time the practical nursing program was instituted by state law, the nurses' board was required to consult with The Medical Society of New Jersey. They have decided, through their attorney, that they were required to consult with the Medical Society but were in no way bound to follow the advice of the Medical Society. So that at the present time there seems to be an impasse between two organizations, in which they say that we have no jurisdiction, no authority over them; and the Committee felt that a fact-finding committee, set up by the Governor, might make recommendations to the Legislature, to us and to the nurses that could help this situation. There are already committees of the Nursing Board, the Department of Health and the State Society working on the problem, but they have gotten nowhere.

President Norton: Is there any further comment?

Before I put the question, I will ask for a suspension of the rules by unanimous consent of the house in order to expedite this matter in accordance with the strictest of parliamentary codes since there is some question that maybe it did originate with the Reference Committee.

Do I hear a motion to suspend the rules by unanimous consent?

(Such a motion was made and seconded.)

President Norton: The motion is on unanimous consent to introduce this resolution from Reference Committee "D". All in favor; contrary minded. So ordered. The question is now on the adoption of the resolution brought in by Dr. Lathrop as Chairman of Reference Committee "D", the resolution you have just heard and which has already been regularly moved and seconded.

Dr. Echikson: No mention is made of medical personnel in that committee. Was it your intent to include *only* lay personnel?

President Norton: That is the intent of the resolution; that is what it spells out: lay personnel.

Dr. Lance: Was it with a view of changing existing legislation, if not, what is the purpose of it?

Dr. Lathrop: To study the situation, perhaps leading to changed legislation. The idea was that the Governor appointed a lay committee to study the Chiropractic Bill when the Medical Practice Act was put in, I understand.

This committee would consult with The Medical Society of New Jersey, with the Department of Health, with the Department of Institutions and Agencies, with the nursing agency.

Dr. Morris: You do have a joint committee within the state now. I attended it as a member of the Medical Society. They are studying this problem, but it does not contain any members of lay groups.

President Norton: How long has your committee been working on it?

Dr. Morris: I was informed about it three weeks ago and attended a meeting at the St. Barnabas Hospital. Twelve members were present. They are to become more completely organized at the next meeting. The nursing situation came before the committee at that time. They are planning for a dinner meeting in October, when they expect to take it up. I don't know whether Dr. Lathrop knows about this.

Dr. Lathrop: We didn't find anybody last night who was able to solve the problem. Is that joint committee actually working on it?

Dr. Morris: Yes. There are five members and a sixth member will be appointed by Dr. Crowe. Thus we will have six members from the Medical Society and six from the State Nurses Association; there will be six representing Hospital Administrators. I think that's all the groups represented; but there will be, as I understand it, about twenty-four members of this group. The name of the committee is Joint Committee for the Study of the Care of the Patient.

I don't know whether Dr. Norton is familiar with it. Did you appoint the committee, Doctor?

President Norton: No, I didn't, but I think this nursing question has been in here for a long, long time. I do not want to discuss it.

Dr. Lance: I applaud the intent of this committee in attempting something that may lead to a solution. But it is a little vague, particularly in view of the fact that it asks the Governor of the State of New Jersey to appoint a commission. The resolution itself has no objective. All they are asking is for the appointment of a fact-finding committee to report to the Governor. They are not saying whether this fact-finding committee is to stimulate a change in the law or for what other purpose it is being formed. I should hate to see the House of Delegates ask the Governor to act upon as vague a thing as this seems to be. This resolution, well-intentioned as it is, ought to be subjected to further study.

President Norton: Well, the resolution

calls for a fact-finding committee to study the entire nursing situation, including both the registered nurse and the practical nurse training program.

DR. SCHAAF: Would it not be possible, Mr. Chairman, to amend the motion to read that it be given the approval of the House of Delegates subject to confirmation after further study by the Trustees? That would enable us to keep it. It would be approved by the Delegates. It could be kept for further study and transmitted or not, as seemed wise.

PRESIDENT NORTON: Well, Dr. Lathrop accepts the amendment. Is there a second to the amendment?

(The amendment was seconded and passed.)

PRESIDENT NORTON: The vote now is on the original motion which you have heard and which you have heard discussed. All in favor of its adoption; contrary minded. The "Ayes" have it.

DR. LATHROP: I move the adoption of the report as amended.

(The motion was seconded and passed.)

PRESIDENT NORTON: Reference Committee "E", to consider the reports of the Welfare Committee, the subcommittees of the Welfare Committee, and the advisory committees to the subcommittees of the Welfare Committee; Dr. Wikoff, of Mercer County, Chairman.

REPORT OF REFERENCE COMMITTEE "E"

Reference Committee "E" met on May 23. Reports of Welfare Committee, the subcommittees and advisory committees were considered and the following actions were taken:

Welfare Committee—report approved.

Subcommittee on Medical Practice—report approved.

Subcommittee on Legislation—report including supplemental approved.

Subcommittee on Public Relations—the following specific recommendations were made by this Committee:

(1) That The Medical Society of New Jersey sponsor another statewide medical press conference in the fall of 1950.

(2) That each county society sponsor and actively support a year-round Speakers Bureau service to provide speakers for lay groups interested in talks on health topics. It is necessary for the medical profession to exert active leadership in public health and to cooperate with all agencies interested in health education by providing such speakers.

(3) That the basic, normal public relations services of the Society be continued through 1950, including the *Membership News Letter* and the quarterly *News Letter* to cooperating agencies, the weekly *Health Hints* service, the *Junior Health Hints* service to schools, and the presentation of A.M.A. radio transcriptions through local radio stations.

(4) That The Medical Society of New Jersey urge each of its component county medical societies to concentrate during the year 1950-51 on an organized public relations and public service program, including the following features:

(a) An emergency call service system in every community to assure adequate and prompt medical service in medical emergencies.

(b) Universal application within each county of the policies of medical welfare service already endorsed by The Medical Society of New Jersey.

(c) The organization or reorganization of county society machinery for handling grievances or complaints against individual members of the profession in accordance with a program to be presented by the Judicial Council.

(d) Leadership in community health affairs through organization of county and local health councils.

(e) Better public recognition of the services of the medical profession through the provision of a reference service for newspapers so that medical news may be properly channeled and authenticated; the holding in each county of a medical press conference between the medical society and local editors; the servicing of local radio stations with A.M.A. transcriptions and, wherever possible, with live programs for health education.

The Reference Committee approved the foregoing recommendations and the report of the Public Relations Subcommittee as a whole and recommend approval by the House of Delegates.

Subcommittee on Public Health—This Committee recommends for the second successive year that the Welfare Committee and Trustees study the problem of obtaining the cooperation of the component medical societies in carrying out the recommendations of the Subcommittee on Public Health.

The Reference Committee approved this recommendation and suggests that the Subcommittee on Public Health might have semi-annual meetings with the county public health chairmen to obtain the cooperation desired.

The report of the Subcommittee on Public Health as a whole was approved.

Adult Disease Control — The Reference Committee took the following actions on this Committee's recommendations about motor vehicle drivers.

1. That any automobile driver involved in a fatal accident be required to undergo a physical examination as soon as practical following the accident—approved.

2. The original recommendation was disapproved and the Reference Committee recommends the following substitute:

That all applicants for a driver's license 60

years of age or over undergo an initial physical examination at the time of making application; and further that all applicants for driver's license 65 years of age or over have yearly physical examinations.

3. That if, in the opinion of the Director of the Division of Motor Vehicles,* an applicant for a driver's license presents any physical or mental defect the applicant be required to undergo a physical examination before a license is granted. Approved.

4. The Reference Committee felt that the first and second sentences of this recommendation were superfluous and should be deleted. The Reference Committee approves the final sentence of this recommendation, "We, the Committee on Adult Disease Control, assure the Division of Motor Vehicles of every possible cooperation from our Committee but feel that it is a responsibility of that Division to make available the personnel required in such an extensive study". I move the adoption of this portion of the report.

Cancer Control—approved.

Cardio-vascular Diseases—approved.

Conservation of Vision and Hearing—approved.

Child Health — the Reference Committee feels that this report is not entirely complete and recommends that it be referred back to the Child Health Committee for further study and specific recommendations.

Crippled Children—The Reference Committee approved the report and the following recommendations:

1. Improved methods for the reporting of unlisted cerebral palsy patients to the Crippled Children Commission of New Jersey and the State Department of Health.

2. Additional technicians are needed, with special training in cerebral palsy, such as physical therapists, occupational therapists and speech therapists, for the state cerebral palsy clinics. Unfortunately, very limited funds are now available to employ such technicians.

3. More of the general hospitals in New Jersey should be encouraged to provide isolation wards or rooms for the treatment of the acute phase of poliomyelitis.

Maternal Welfare—approved.

Mental Hygiene—approved.

Rural Health—approved. The Reference Committee endorses the last sentence of this report in which the Committee urges the county societies to lend better support to their auxiliary next year in their efforts to continue and expand the rural health program. The Reference Committee recommends that this point be emphasized to the county societies.

School Health—approved.

Tuberculosis — approved. The Reference Committee reiterates the action of this House in 1947 when it adopted the seven-point program of the Tuberculosis Committee, the first point of which was, "The x-raying of all hospital admissions and clinic cases routinely when feasible." The Reference Committee recommends that steps be taken to effect this procedure.

Tropical Diseases—approved.

Venereal Disease Control—approved.

Anesthesiology—approved.

Contract Practice—approved.

Hospital Relationships—approved.

Industrial Health and Hygiene—approved. The Reference Committee feels that the resume of the report of the proceedings of the Congress on Industrial Health in New York forms an excellent outline for the guidance of a committee in meeting industrial health problems in New Jersey. We suggest that next year's Committee be guided by this outline and take steps to implement such a program in New Jersey.

Laboratory Medicine—approved.

Medical Care of the Indigent — approved. We endorse the reiteration of last year's action of this House of Delegates and approve the Committee's recommendation, "That Welfare authorities purchase non-profit Blue Cross and Blue Shield insurance coverage for the medically indigent. This will help the communities to meet their legal responsibility for providing service for people not on relief but with incomes insufficient to withstand the economic consequences of catastrophic illness."

Nursing and Nursing Education—approved.

Pharmaceutical Problems—The report stated that the dispensing of medicines by nurses in physicians' offices and industrial plants was condemned in a recommendation to the Medical Practice Committee. The Reference Committee recommends that this portion of the report be referred to the Committee on Industrial Health and Hygiene for action.

The Reference Committee recommends that the State Society protest to the Pure Food and Drug Administration the open sale of anti-

*At the time this correspondence was initiated, administration of motor vehicles was the function of the Department of Motor Vehicles, headed by a Commissioner. However, early in 1949 the structure of the state government was changed and the Department of Motor Vehicles was allocated to the Department of Public Safety as the "Division of Motor Vehicles". Similarly, the title of the chief executive officer of the division was changed from "Commissioner of Motor Vehicles" to "Director of the Division of Motor Vehicles". Accordingly references to the Department and Commissioner have been changed to read "Division" and "Director" respectively, since at the time the discussion took place the new titles were in use.

histaminics stating the potential dangers and reactions of the drug.

Physical Medicine—approved.

Radiology—approved.

Workmen's Compensation—approved.

We commend the Public Health Committee for the formulation of standards for the control of an outbreak of poliomyelitis which are in keeping with the Committee's long-standing policy that everything pertaining to the Public Health of our citizens is the direct responsibility of the medical professon.

We commend the Subcommittee on Legislation for its excellent coverage of legislation, both federal and state, and their untiring efforts in the interests of the medical profession.

The Reference Committee compliments all the committees for their excellent reports and commends them for their efforts in the interests of the Society and its members.

(Dr. Wikoff read the beginning of the Report of Reference Committee "E". The various committee reports on those pages were adopted upon motions regularly made, seconded and carried. He then read Sections 1 to 4, Adult Disease Control, after which he stated:)

Dr. Wikoff: I move the adoption of this portion of the report.

President Norton: You are now moving the adoption of this Adult Disease Control, and the specific recommendation is what?

Dr. Wikoff: For approval of these recommendations to the Director of the Division of Motor Vehicles.* We changed the one that automobile drivers involved in a fatal accident be required to undergo a physical examination; and the other at 60 years of age have an initial physical examination, and at age 65 have a yearly physical examination; and that if, in the opinion of the Director of the Division of Motor Vehicles, an applicant for a driver's license presents any physical or mental defect he may be required to undergo a physical examination; and the Director of the Division of Motor Vehicles also be advised that the Medical Society cannot undertake this program but it is the duty of his Division.

President Norton: Do you understand the recommendation?

(There were several Noes.)

President Norton: Will you amplify it?

Dr. Wikoff: The Director of the Motor Vehicles Division asked us to take this matter under advisement. Dr. Blaugrund's committee took this matter up and submitted these four recommendations, which I have read to you, to be forwarded to the Director of the Division.

Dr. Blaugrund: The Director of the Division of Motor Vehicles wanted a survey made of all the accidents in the last fifteen years and he wanted specific recommendations. To make that survey the Medical Society would have to spend thousands of dollars and use a large staff to survey the records of the last ten or twenty years in order to come to a definite conclusion. Our Committee did not deem it advisable for the Society to assume this responsibility and expense. We did not want to turn his request down flat, and suggested that the Division of Motor Vehicles do the survey, make the study wth their personnel and their money, and after they had their report completed and the survey in good shape, they could present it to the Medical Society for our study and for our opinion. That is the gist of Number 4.

Dr. Reuben Sharp (Camden): I certainly couldn't get that out of that last statement as it was read from the platform. And as I get it, we were supposed to examine men over sixty years of age. I don't see that it is in that report at all.

Dr. Blaugrund: That is Point 4, that the survey be referred back to the Director of the Division of Motor Vehicles for study. As for physical examination at age levels, that met the approval of the Public Health Committee; that part wasn't even under discussion, and the Reference Committee, as I understand it, approved those recommendations.

We did not obligate the Medical Society to do the survey and the study, which would probably take two to five years, at a tremendous expense. That was the only thing that we refused to endorse. As I understand it, that is the recommendation of the Reference Committee, that it be put in the laps of the Motor Vehicle Division, not in our laps.

Dr. Wikoff: Point 4: "We, the Committee on Adult Disease Control, assure the Director of the Division of Motor Vehicles of every possible cooperation from our Committee but feel that it is a responsibility of his division to make available the personnel required for such an extensive study." In the original recommendation there was the first and second sentence to that paragraph, but we thought it was superfluous and should be deleted.

Dr. Wegrocki: I think we must be cognizant of the fact that that request came from a gentleman who is no longer Director of that Division. Mr. Magee was recently succeeded by Mr. Ferber in that post. There has been

for a number of years, dissatisfaction with the Division of Motor Vehicles; editorial comment has been rather acid on the score of interference with the rights and privileges of drivers. The Division has been under attack for increasing bureaucratic control by the Division over the average driver. It would be poor judgment at this time, when the Governor recognizes that criticism and when the change has been made in the personnel of the Division, to have this type of recommendation adopted. The letter and the answer would go to the new Motor Vehicle Director who did not make that request.

President Norton: I think we should dispose of it as coming from the Director of the Division of Motor Vehicles. We can have an awareness of the personalities involved but I think we should consider it as coming from the Director of the Division of Motor Vehicles and dispose of it accordingly.

Dr. Coleman: I move the recommendation regarding all matters pertaining to the Motor Vehicle Division be tabled.

(The motion was seconded and passed.)

Dr. Wikoff then read the remainder of the report, each section of which was adopted upon motions regularly made, seconded and carried.)

Dr. Wikoff: Mr. President, I move the adoption of this report as a whole, with the exception of that portion relative to the Motor Vehicle Division.

President Norton: You have heard the motion offering the adoption of this report with the exception of that portion referring to Motor Vehicle problems, which has been tabled.

(The motion was seconded and passed.)

President Norton: Thank you very much, Dr. Wikoff. The next Committee to report is the Reference Committee on Constitution and By-Laws, to consider amendments to the Constitution and By-Laws; Dr. Haggerty from Mercer.

Dr. D. Leo Haggerty: Mr. President. Members of the House of Delegates: The Reference Committee on Constitution and By-Laws met at 8:30 last night with a full attendance of its membership. Dr. Konzelmann was appointed Secretary. Three items were presented for consideration.

(Dr. Haggerty then read A.)

A

REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

The Committee on Medical Defense, deeply conscious of the intricate problem relative to insurance, recommends the addition of two young men to that committee in order that through the years they may gain experience in the business of the committee.

It is recommended that Section 12 of Chapter VIII be amended to read, "The Committee on Medical Defense and Insurance shall consist of seven members——".

Dr. Haggerty: Your Reference Committee moves for the adoption of this section.

President Norton: You have heard the recommendation of Dr. Haggerty on this portion of his report referring to the addition of two members to the Medical Defense and Insurance Committee. Do I hear a second?

(The motion was seconded and passed.)

(Dr. Haggerty then read B.)

B

The Monmouth County Medical Society recommends that Section 2 of Chapter IX be amended by the insertion of the following in Line 10, Page 42.

"Provided, however, that no assessment shall be levied against any component society for any member who is exempted by the component society from the payment of annual dues for financial reasons. Such exemptions are to be for one year only, and if it is necessary to continue exemption for a longer period, reapplication must be made to The Medical Society of New Jersey and in no case shall exemption be continued for a period longer than three years."

Your Reference Committee approves the amendment as recommended.

Dr. Haggerty: Your Reference Committee moves for the amendment as recommended.

(The motion was seconded and passed.)

(Dr. Haggerty then read C.)

C

The Judicial Council has recommended certain amendments to the Constitution and By-Laws in order to bring the activities of the Judicial Council in line with the recommendations of the American Medical Association.

1. That the House of Delegates request the Judicial Council, as its first order of business during the administrative year 1950-51, to draw up in consultation with legal counsel, a recommended set of uniform by-laws providing for establishment of county society judicial committees which by-laws will be proposed by the Judicial Council to the several county societies.

2. That the House of Delegates officially request each county society, on receipt of the recommended uniform by-laws, to take whatever steps may be necessary to adopt such by-laws for the county society at the earliest possible date.

3. The adoption of the certain amendments to the Constitution and By-Laws of The Medical Society of New Jersey; recognizing that the proposed amendments to the Constitution cannot become effective until one year from this time.

Dr. Haggerty: Your Reference Committee moves that these recommendations be approved.

(The motion was seconded.)

President Norton: Do I hear a discussion? You are now voting on the three specific recommendations of this House of Delegates to the county societies to establish a uniform committee, complaint committee, ethics committee, local county judicial council, or whatever you want to call it, after they have set up a uniform state-wide standard on a county basis in consultation with the Council of the State Society. That is the import of the recommendation.

Are you ready for the question? All in favor signify by saying "Aye"; contrary minded. It is so ordered.

You are now going to hear some proposed changes in the Constitution upon which you are not now required to act but which, the Constitution demands, shall be read at this meeting and laid over until the next meeting. So the next portion of the report of Dr. Haggerty requires no action at this meeting of the House of Delegates.

(Dr. Haggerty read D and E.)

D

The Judicial Council recommends and your Reference Committee approves the folowing amendments to the Constitution:

(1) Article V—House of Delegates

Delete the phrase "and shall hear appeals from the decisions of the Judicial Council,".

The amended Article will then read: "The House of Delegates shall be the *legislative* body, and shall consist of the Fellows, Officers and Delegates".

Your Reference Committee recommends that this amendment be approved to follow the course prescribed in the Constitution for amendments to the Constitution.

E

(2) Article VII—Councilors

Amend this article to read as follows: "The Councilors collectively shall comprise the Judicial Council which shall be the *judicial* body of the Society. The House of Delegates shall organize five (5) councilor districts within the state. It shall elect one (1) councilor to represent each district from among the membership of each such district."

Your Reference Committee approves this amendment and recommends it to follow the course prescribed in the Constitution for amendments to the Constitution.

President Norton: This will be laid over for one year, to be acted upon at the next meeting of the House of Delegates. There is one more to come, amending the Constitution.

(Dr. Haggerty read F.)

F

(3) Article IX—Officers

Amend Section 2 — "Election" (first line) now reading: "The Officers shall be elected by this Society. . ." to read: "The Officers shall be elected by the House of Delegates. . ."

Your Reference Committee endorses this amendment and suggests that it follow the course prescribed in the Constitution for amendments to the Constitution.

Dr. Haggerty: Now, the Judicial Council recommends the following amendments to the By-Laws, which can be acted upon now.

(Dr. Haggerty read G.)

G

The Judicial Council recommends the following amendments to the By-Laws:

Chapter IV—House of Delegates—

Section 5—Appeals

Delete Section 5, reading: "It shall hear and finally determine all appeals taken from decisions of the Judicial Council."

Section 6—Final Authority.

Section number to become "5".

Section 7 — Business During the Last Session.

Section number to become "6".

Your Reference Committee recommends the deletion and the proper change in numbering.

President Norton: We will do this piece by piece so that you will know what you are

doing because it gets a little bit involved if you don't act upon it portion by portion.

Dr. Haggerty: The Reference Committee moves for the deletion and the proper change in numbering.

(The motion was seconded.)

President Norton: It has been regularly moved and seconded that the change in the By-Laws as set forth by the Judicial Council and recommended by the Reference Committee, as already read, shall be approved. You are now changing the By-Laws, and this House of Delegates has authority today to do it. All in favor of the recommendation as read signify by saying "Aye"; contrary minded. It is so ordered.

(Dr. Haggerty read H.)

H

Chapter VII—Judicial Council—

Section 1—Election

Delete the last sentence, reading: "The President shall be a member of the Council *ex-officio.*"—to bring this section into agreement with the amendment to Article VII of the Constitution.

Your Reference Committee recommends the deletion of this last sentence.

Dr. Haggerty: Your Reference Committee moves for the deletion of this last sentence.

(The motion was seconded.)

President Norton: What you are doing is taking the President *ex-officio* off the Judicial Council. All in favor of the amendment of the By-Laws affecting this deletion signify by saying "Aye"; contrary minded. It is so ordered.

(Dr. Haggerty read I.)

I

Section 2 — Censors *(change title* to "Councilors")

Delete the present section, reading: "The Councilors collectively, shall constitute a Board of Censors of this Society known as the Judicial Council", and substitute the following as Section 2:

"The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of the Society."

Your Reference Committee recommends that titles be changed as suggested.

Dr. Haggerty: Your Reference Committee moves that titles be changed as recommended.

(The motion was seconded.)

President Norton: Do you understand the question? It is a change in phraseology. It has no import except one thing: It does establish the Judicial Council as the supreme judicial body of the State Society. In the By-Laws under which we are operating there is provision for appeal from the decisions of the Judicial Council to the House of Delegates. This eliminates the appeal from the actions of the Judicial Council to the House of Delegates and establishes the primacy of the Judicial Council.

Is there any comment?

Dr. Costello: What is the purpose of that?

President Norton: I can answer it, but I'd rather have Dr. Haggerty do it.

Dr. Haggerty: Under the change, the Judicial Council is the judicial body of the Society now. The President and his staff are the executive and the House of Delegates is the legislative. In the past—and that is what the A.M.A. objected to—matters of a judicial nature were being referred to the legislative body which "made the laws", which of course is not good business, and they asked for this change.

Instead of appealing to this body, you appeal directly to the supreme council of the A.M.A. That is the tie-up.

President Norton: The original structure provides for an appeal from the Judicial Council to the House of Delegates; but it says that all the material and everything before the Judicial Council can be privileged and confidential, and when an appeal comes to the House of Delegates, the House of Delegates has no access to the evidence or anything else that the Judicial Council hears. Do you understand? This House of Delegates is supposed to render a decision on an appeal from the Judicial Council, but are denied access to the records, to the evidence, to the material and what not upon which the Judicial Council predicated its decision. It is an anachronism; we ought to clear it up and make it straight.

All in favor of the proposed change as indicated signify by saying "Aye"; contrary minded. It is so ordered.

(Dr. Haggerty read J.)

J

Section 3—Meetings.

Delete the present Section, reading: "The Judicial Council shall meet on the evening before the annual meeting of the Society, and subsequently at the call of the chairman, or upon the petition of three of the Councilors, at such time and place as necessity or convenience requires. Four members shall constitute a quorum." and *substitute* the following as Section 3:

"The Judicial Council shall meet immediately following the election of officers for the purpose of organization. Thereafter, the Judicial Council shall meet as often as may be necessary to transact its business, at the call of the chairman. Three members shall constitute a quorum."

Your Reference Committee endorses the deletion and substitution as recommended.

Dr. Haggerty: Your Reference Committee moves the deletion and substitution as recommended.

(The motion was seconded and passed.)

(Dr. Haggerty read K.)

K

Section 4—Ethics and Discipline.

Delete the present title of this Section and substitute "Duties of the Judicial Council".

Delete the present section, reading: "All questions of an ethical nature shall be referred by the House of Delegates or the Board of Trustees without discussion to the Judicial Council. It shall consider and decide all questions of discipline affecting the conduct of members. It shall consider all questions involving the rights of members, whether in relation to each other, to component societies, or to this Society. It shall also consider complaints of lay groups or persons against members of this Society." and *substitute* the following:

"The duties of the Judicial Council shall be as follows:

"(1) To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other Board or Committee of the Society.

"(2) To adjudicate all disputes or controversies arising within The Medical Society of New Jersey.

"(3) To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate District Judicial Council, to be established as hereinafter provided and, in general, to expedite the actions of the several District Judicial Councils in the interest of assuring prompt and equitable handling of all such matters brought to the attention of the Society.

"(4) To receive, consider and rule on any matter of discipline concerning any member or members of the Society brought to the Judicial Council on appeal from a county Judicial Council or equivalent body of a County Medical Society."

With the approval of Dr. Butler your Reference Committee replaced the sentence, "supervise the activity" with "expedite the actions of the several District Judicial Councils—".

Your Reference Committee endorses the deletion and substitution of this section as amended.

Present Section "5"—Appeals, to be changed to "Section 10" and the following new Sections 5, 6, 7, 8, and 9 to be added.

Dr. Haggerty: Your Reference Committee moves for the deletion and substitution of this section as amended.

(The motion was seconded.)

President Norton: The deleted and substituted rendition is now up for adoption.

Dr. Paul B. Ferrary (Passaic County): At the meeting of the Committee last night there were some of us who felt that under Section 4, "The duties of the Judicial Council shall be as follows," then the second item: "To adjudicate all disputes or controversies arising within The Medical Society of New Jersey"—we felt that that was too broad a statement of duties and should be delineated somewhat and there was some talk of adding to that "which may be presented to it," following "The Medical Society of New Jersey". The Committee did speak of that but passed it as it was printed. A number of us felt that the duties were laid down in too ambiguous terms.

Dr. Morris: Mr. President, is there any clause about a hearing for the accused?

President Norton: Yes, that will be developed.

Any further discussion? Are you ready for the question? All in favor of this revision of the By-Laws as recommended by the Reference Committee on Constitution and By-Laws concerning the duties of the Judicial Council in the new setup signify by saying "Aye"; contrary minded. The "Ayes" have it; it is so ordered.

(Dr. Haggerty read L.)

L

Section 5—District Judicial Councils

"There shall be a district judicial council in each Judicial District in the State, to be known as a 'district council'. Each district council shall consist of two members by each component county medical society within the district, together with the Judicial Councilor elected by the House of Delegates of The Medical Society of New Jersey to represent the district. Each elected member, except the chairman, shall serve a term of two years, the term of one member representing each county society terminating on May 31 each year. No member shall be eligible to serve simultaneously as a member of a district council and of a county so-

ciety judicial committee. A quorum of a district council shall consist of five members, exclusive of the Judicial Councilor, and action shall be taken by majority vote of those present.

"The Judicial Councilor shall serve as the chairman of the district council in his district. He shall be generally responsible to the Judicial Council for the administration of the affairs of the district council. He shall render a report at each meeting of the Judicial Council relative to the work of the district council over which he presides. Such report shall include a record of the disposition of all complaints or other matters referred to or considered by the district council. He shall have voice but shall not vote in the deliberations of the district council.

"Each district council shall also elect from among its members a secretary, and a vice-chairman who, in the absence of the chairman, shall perform the duties of the chairman."

Your reference committee endorses the addition of this section to the by-laws.

Dr. Haggerty: Your Reference Committee moves for the addition of this section to the By-Laws.

(The motion was seconded and passed.)

(Dr. Haggerty read M.)

M

Section 6—Procedure for Considering Grievances

"Any complaint, allegation or grievance concerning a member of the Society, when received by the Judicial Council, shall be referred to the Judicial Councilor from the district in which the physician complained against maintains membership. Thereafter the Judicial Councilor shall present the matter at the earliest opportunity to the district council of which he is the chairman.

"Upon receipt of such a complaint, allegation or grievance, the district council shall make such investigation as may be required to determine all the relevant facts and circumstances. Such investigation shall be conducted in a strictly confidential manner, and in accordance with rules of procedure to be established by the Judicial Council. The physician concerned will have the right to appear on his own behalf.

"If, after careful investigation, the district council finds no cause for recommending disciplinary action against the physician or physicians involved, the case shall be closed and a report of such disposition shall be made to both parties and, through the chairman, to the Judicial Council.

"If the district council finds that a complaint, allegation or grievance can be settled by conference and conciliation between or among the parties, or if the district council determines that the interests of the parties involved will be best served by the rendering of private advice to the physician in question, then the case shall be considered closed and a report of such disposition shall be made to both parties and to the Judicial Council.

"If, after careful investigation, the District Council finds that there is *prima facie* evidence warranting disciplinary action, it, (in consultation with the Society's legal counsel) shall prepare or cause to be prepared a formal written complaint against the accused. The accused shall be furnished immediately with a copy of the complaint. The district council shall then present or refer such complaint to the judicial committee of the county medical society of which the accused is a member, for appropriate action by such county judicial committee.

"If the district council finds that a complaint, allegation or grievance involves a matter which would empower the State Board of Medical Examiners to revoke or suspend a practitioner's license, it shall be the duty of the district council forthwith, by written complaint, to refer the case to the Judicial Council which shall, in turn, refer the complaint to the State Board of Medical Examiners."

With the approval of Dr. Butler, Chairman of the Judicial Council, this section was amended by the addition of "The accused shall be furnished immediately with a copy of said complaint". Your reference committee endorses the addition of this section to the by-laws as amended.

For better sequence section 7 should be numbered section 9. Sections 8 and 9 should be moved to occupy the position of sections 7 and 8 respectively and so numbered.

Dr. Haggerty: Your Reference Committee moves for the addition of this section to the By-Laws as amended.

(The motion was seconded.)

President Norton: This amendment has been regularly moved and seconded. Is there a discussion?

Dr. Murphy: Mr. President, I read that—"Upon receipt of such a complaint, allegation or grievance, the District Council shall make such investigation as may be required to determine all the relevant facts and circumstances. Such investigation shall be conducted in a strictly confidential manner, and in accordance with rules of procedure to be established by the Judicial Council." So far I am in favor of all that.

I'd like to amend this to add: "The physician concerned will have the right to appear in his own behalf," immediately after the "established by the Judicial Council".

I understand it is considered to be inherent, but it doesn't say so, and I think it ought to be spelled out. And I move you, sir, that that particular paragraph be amended to have the

sentence added: "The physician concerned will have the right to appear in his own behalf."

(The motion was seconded.)

President Norton: You are offering that as an amendment to this report?

Dr. Murphy: That's right, sir.

President Norton: Is there a second to the amendment?

(The motion was seconded.)

Dr. Butler: There is no intention of denying the accused the right of appearing. In fact, unless he were there, a proper investigation could not be made. Our purpose in establishing a district council was merely to give an opportunity to people who had a grievance and wanted to bring that grievance in, to expedite and to settle a lot of these things, if we could, privately. If a matter can be settled locally, that ended it as far as that particular case was concerned. If it were of a minor nature, no publicity would be given.

On the other hand, we did not presume to be the trial body. We were merely acting in the capacity of a "grand jury" and finding out if there was a serious complaint. In order that we would not interfere with the functions of a local county committee (which would be the final body to hold a trial of this member) we felt that all that should be done was to present our findings, in conjunction with the legal counsel, which would then be channeled into the county society where the man would then be tried. There, of course, he would have his trial. No such procedure applies to the district council. We saw no need for it; we still see no need for it and I think that it is not necessary. If we feel that the man should come there, we are certainly going to call him. I don't think that his rights are infringed on in any way; after all he is *not* being tried. All we want to find out is: is this a minor or a major problem? If it is a minor problem we are going to try to settle it. If it is a major problem, it goes back to his county society committee to settle.

Dr. Murphy: I realize all that and I realize, Dr. Butler and the Council have done a good job in drawing this up. I also realize in the preamble they state a lot of this can be settled on the state and district level without going to the county; and reading on—and we haven't come to that yet—but on the next page it says :

"If the District Council shall find that a complaint, allegation or grievance involves a matter which would empower the State Board of Medical Examiners to revoke or suspend a practitioner's license, it shall be the duty of the District Council forthwith, by written complaint, to refer the case to the Judicial Council which shall, in turn, refer the complaint to the State Board of Medical Examiners."

It doesn't say it is going to go to the county at all; it says it is going from that particular council and from the Judicial Council to the Board of Medical Examiners and the man will never be heard. Dr. Butler may mean to bring the man before them if they think they need him; but it is my point that he should have the *right* to come in whether they think they need him or not. My amendment does no harm and it clarifies the situation. The physician concerned should have the right to appear in his own behalf. It is a principle of American and English Law. Any man has a right to be heard in his own behalf before action is taken against him. I still move the amendment, sir.

Dr. Robie: I rise in concurrence with Dr. Murphy's position. It is an inherent right of any man to appear in defense of himself in a democracy.

Prseident Norton: Well, I don't want to get into it, but you have no right to appear before a grand jury. However, I am going to put the amendment as offered. I am going to put the question, don't worry about that.

Dr. Burritt: Wouldn't this Society feel horrible five years from now to find out that we were wrong? The Board of Censors has done a wonderful job, but if their job is not good enough in protecting the right of the individual physician of this Society, whch is their intent, wouldn't it be horrble if they were wrong?

President Norton: Well, I would like to be down there where I could talk a bit, but we have another responsibility. We have a responsibility to the people of the State, too. Any further discussion? All in favor of the amendment as offered by Dr. Murphy signify by saying "Aye"; contrary minded. The "Ayes" have it.

You are now voting on the original recommendation of the Reference Committee as amended. All in favor signify by saying "Aye"; contrary minded. The "Ayes" have it.

(Dr. Haggerty read N.)

N

Section 7—Administration and Procedure

"The administrative and legal costs of the operation of the Judicial Council and of the district councils shall be underwritten by The Medical Society of New Jersey in accordance with an annual appro-

priation for these purposes to be approved by the House of Delegates.

"Every matter coming before a district council shall be considered in a strictly confidential manner. The records of the district council shall be maintained under the supervision of the Judicial Councilor for that district, and shall be subject to inspection exclusively by members of that Council and by legal counsel for the Society. Except for purposes of consultation or testimony as required by the district council, no member or officer of the Society shall be present at a meeting of a district council when any complaint is under consideration.

"In pursuance of its investigatory and judicial functions, the district councils shall have authority to summon members of the Society to appear and testify, either in connection with a complaint involving the member summoned, or as witnesses in cases involving other members. In case any member fails to respond to such a summons, the district council shall be, and hereby is, authorized to cite such a member to his component society for contempt. Such a citation shall be considered equivalent to a charge of unethical conduct and shall take the course provided in Section 9.

"The Judicial Council shall make and publish rules and regulations subject to approval of The Medical Society of New Jersey for the conduct of investigations, the disposition of cases, and the formulation of formal complaints by the several district councils. Such rules shall specify periods of notice, procedure for disposition of complaints against physicians who are not members of the Society, procedures for notification of complaints and defendants, maintenance of proper records and other pertinent regulations."

With the approval of Dr. Butler, Chairman of Judicial Council, this section was amended by the addition of "subject to approval of The Medical Society of New Jersey". Your reference committee approves the correction in numbering and for the addition of this section to the by-laws as amended.

Dr. Haggerty: Your Reference Committee moves for the correction in numbering and for the addition of this section to the By-Laws as amended.

(The motion was seconded.)

President Norton: Is there a discussion?

Dr Alexander: Has that procedure been passed on by legal counsel?

President Norton: Dr. Alexander, I can tell you, without calling upon the Judicial Council, that this matter has been studied for the entire year and the whole draft as submitted to the House of Delegates at its opening session on Tuesday has been gone over, revised, rewritten, revamped by the counsel of the State Society many times.

Are you ready for the question? All in favor of the change in the numbers and the revision as indicated signify by saying "Aye"; contrary minded. The "Ayes" have it.

(Dr. Haggerty read O.)

O

Section 8—Special Procedure for Complaints

"In a complaint involving the just or proper amount of a fee for professional services, the district council shall first investigate and attempt to effect an amicable settlement. If the district council be unable to reconcile the differences, then it may determine the fee which it considers just and proper under all the circumstances of the particular case. If the Society member against whom the complaint is brought agrees to abide by the decision of the district council and registers this agreement with the patient in a form to be prescribed for this purpose, then the case shall be considered closed and only an impersonal statistical report shall be rendered by the chairman to the Judicial Council.

"If, however, the member agrees to the amount of the fee so fixed but fails to abide by his agreement, then the district council may cite such a member for contempt and so notify the judicial committee of his county medical society for appropriate action.

"If a member fails to accept such a determination in the first instance, such action may, in the discretion of the district council, constitute grounds for the preferring of formal charges by the district council to the county society judicial committee."

Dr. Haggerty: Your Reference Committee moves for the addition of this section to the By-Laws.

(The motion was seconded and passed.)

(Dr. Haggerty read P.)

P

Section 9—Functions of County Judicial Committees

"Upon receipt of a formal complaint from the district council, the county society judicial committee shall hear and try the matter in accordance with its by-laws and established rules of order. If the county judicial committee determines that disciplinary action is warranted against the accused, it shall take such action in accordance with the by-laws of the county medical society. A report of such action shall be filed with the Judicial Council."

Your reference committee favors the addition of this section to the by-laws.

Dr. Haggerty: Your Reference Committee moves for the addition of this section to the By-Laws.

(The motion was seconded and passed.)

(Dr. Haggerty read Q.)

Q

Present section 5—"Appeals" changed to Section 10.

Section 10—Appeals

"Any member of a component county society aggrieved by an action of the county judicial committee, or any applicant for membership who has been excluded from membership by a county society, or any lay person aggrieved by an action of the county society judicial committee may appeal from the decision or action of the county society or the county judicial committee to the Judicial Council.

"Decision of the Judicial Council in any matter so appealed shall be final, except that further appeal may be taken by either party to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

"Any appeal to the Judicial Council of The Medical Society of New Jersey must be filed with the Judicial Council within 45 days of the date of the formal notice to the aggrieved party of the action of the component society or of the county society judicial committee.

"Form of notice of appeal and procedure in hearing and adjudication of same shall be in accordance with rules of procedure to be established by the Judicial Council, which shall be made available to the parties involved.

"Upon filing a notice of appeal, the appellant and the component society or county society judicial committee will be required to submit to the Judicial Council all records and papers relative to the matter under appeal. All such papers shall be treated confidentially by the Judicial Council.

"The Judicial Council may affirm, modify or reverse, by a majority vote of its members present and voting, the appealed decision. The Judicial Councilor presiding as chairman of the District Council shall not be eligible to sit on any appeal taken to the Judicial Council as herein provided. The Judicial Council may summon witnesses, take new evidence and investigate the appealed matter, in any manner required to develop the information necessary for a proper decision.

"Until such time as the Constitution, Article V, shall be amended to remove from the House of Delegates the function of hearing appeals from the decisions of the Judicial Council, such appeals shall be heard and adjudicated by the House of Delegates, rather than by the Judicial Council of the American Medical Association. Upon the approval of such amendment to the Constitution, this paragraph shall be stricken from the By-Laws."

Your reference committee approves the change in numbering and the addition of this section in the by-laws.

Dr. Haggerty: Your Reference Committee moves for the change in numbering and the addition of this section in the By-Laws.

(The motion was seconded and passed.)

Dr. Haggerty: Now, your Reference Committee moves that the report of the Judicial Council subject to the special provision in the constitution concerning amendments to the constitution be approved as a whole, as amended.

(The motion was seconded and passed.)

President Norton: The next Reference Committee is the Committee on Miscellaneous Business. Dr. Marcus Newcomb, Chairman.

(Dr. Newcomb read the report of the Reference Committee on Miscellaneous Business.)

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

The Miscellaneous Business Reference Committee met on May 23.

The report of the Annual Meeting Committee, the Subcommittee on Scientific Program, the Subcommittee on Scientific Exhibits, the place and dates for the 1951 Annual Meeting were considered and approved.

Our committee recommends to the House of Delegates that the Eye, Ear, Nose and Throat Section be placed on the program annually.

President Norton: Is there a second to the recommendation?

(The motion was seconded.)

President Norton: Any discussion?

Dr. Murray: May I say something? I might say in a poll taken this year there were 65 members present at the meeting of the Eye, Ear, Nose and Throat Section and there has consistently been between 30 and 60 members. We are considering a revision of our sections and in September there will be a meeting of the chairmen and secretaries of the different sections so that each year every section will be represented.

President Norton: Are you ready for the question? The question is on the establishment of a section on Eye, Ear, Nose and Throat at the annual meeting. That has been regularly moved and seconded by the Chairman of the Reference Committee.

Dr. Burritt: The section is already established.

President Norton: That they be on the program. Not the section established; I mean that they be given a place on the program every year.

Dr. Murray: That they be given a place on the program next year and annually.

President Norton: There is no harm in doing this.

Dr. Corio: Then we have been misinformed. We were informed at our section meet-

ing last Monday that we were going to appear once every two years and we felt that that was too long a time for a section to go and that interest in this section would be lost entirely and that is why we came up with this motion.

President Norton: And we have been misinformed evidently.

Dr. Murray: Last year we attempted this plan of alternating section meetings because we had twenty sections to meet each year. Next year we plan to go back to the original procedure of allowing each section to meet each year. We could not do that this year. This was on an experimental basis and every chairman and secretary was informed of that.

Next year we plan to allow each section to meet. There will have to be a combining of sections as there has been in the past. We cannot possibly have twenty sections in two days. We plan to do that. It will require a lot of revamping.

I might say that this is the best turnout that we have ever had, numerically, at the sections. There had been as few as ten and fifteen at a section meeting in the past.

We plan, though, in our revamping next year to have every section represented; so I do not think, Mr. Chairman, that this is necessary.

President Norton: It won't do any harm.

All in favor signify by saying "Aye"; contrary minded. It is so ordered.

Dr. Newcomb: The Committee recommends to the House of Delegates that the program next year contain a section on general medicine, general surgery, general obstetrics, and gynecology, consisting of four papers of 20 minutes each in duration, with 10 minutes for general discussion from the floor. That is a recommendation by some members of the committee.

President Norton: It wasn't sent to you originally?

Dr. Newcomb: No.

Dr. Yaguda: I'd like to move that this resolution be referred to the Annual Meeting Committee.

(The motion was seconded.)

President Norton: I am going to rule the whole thing out of order, because it didn't come before the house at its organization meeting on Monday and it has no place in here. If they want to come up next year with it, present it at the organization meeting and bring it in the regular order of business.

Dr. Newcomb: The Committee recommends that the House of Delegates convene at 10 a. m. on the first day of the meeting. Some members appeared before the Committee concerning the time of meeting of the House of Delegates.

President Norton: We organize and we ask for new business, we ask for resolutions and we ask for memorials and we ask for anything that you have on your minds, and then instead of the matter being presented formally and in order to the House of Delegates so that it can be referred to a Reference Committee, some people are availing themselves of a rather circuitous route to get their matter in and they go before a Reference Committee with it and they offer new business to the Reference Committee.

I am going to rule this out of order, too. It doesn't come before the House in the proper form, and I am not passing upon the merits of either one of these two proposals and I would indicate to those who are interested in it that they put the thing in order for next year's meeting and proceed in the manner in which the House is organized. (Applause)

Dr. Newcomb: Several delegates from the Essex County delegation appeared before the Committee and the Committee makes this recommendation; we couldn't make the recommendation. They appeared and wanted the dates of the meeting changed from Monday, Tuesday and Wednesday to Tuesday, Wednesday and Thursday. We are referring this to the House of Delegates without recommendation.

President Norton: How did it come before your Committee?

Secretary Greifinger: I appeared.

President Norton: Did it come at the organization meeting?

Secretary Greifinger: Yes, it did.

President Norton: Well, that should be easy to find out. You are the Secretary.

Well, I am going to recess this matter for a minute until we finish up with what we have, so we come back to this. Have you anything else?

Dr. Newcomb: No, that is all.

President Norton: The Chair will recess for a matter of about three minutes to give the Parliamentarian, the Secretary of the Society and the Chairman of the Committee a chance to get together on this thing.

(Discussion off the record.)

President Norton: After a deliberation between the Parliamentarian, the Secretary of the State Society and the Chairman of the Committee, the matter has been ruled out of order.

Thank you, Dr. Newcomb.

I think now it is in order to adopt the report of Dr. Newcomb's committee.

Dr. Newcomb has moved for the adoption of the report of the Reference Committee on Miscellaneous Business as a whole, with the corrections as indicated. All in favor indicate by saying "Aye"; contrary minded. It is so ordered.

The next item is the report of the Reference Committee on Resolutions and Memorials, which considers also the reports of the Committee on Honorary Membership and Nominations for Emeritus Membership. Dr. Chester Ulmer from Gloucester.

(Dr. Ulmer read the complete report of the Reference Committee on Resolutions and Memorials.)

REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

The Reference Committee on Resolutions and Memorials met on May 23.

1. We first approved of the nominations for emeritus membership as proposed by the various county medical societies.

2. We then considered a resolution on the Woman's Auxiliary which was approved.

3. We approved the resolution on "Public Health Week", and also approved the resolution on the "New Jersey Plan".

4. We approved of the resolution concerning interns presented by the Union County Medical Society with the following changes. The changes are italicized below:

"Resolved: That the Union County Medical Society respectfully solicit The Medical Society of New Jersey to request the delegates to the A.M.A. to present to the House of Delegates at the A.M.A. convention in San Francisco in June 1950, a resolution *requesting* the A.M.A. to *urge* a two (2) year *internship of which at least one year will be rotating;* and be it further resolved,

That *the number of* interns be *allocated* to approved hospitals by the A.M.A. on the basis of bed capacity of *each* hospital or the number of admissions per year or both so that all hospitals approved by the A.M.A. may receive a sufficient number of interns to expediently and efficiently provide the proper care required for the sick.

5. The resolution from the Physicians Post 445 of the American Legion opposing S.2008 was approved.

Dr. Ulmer: Mr. President, we submit to you this approving report of the Committee on Resolutions and Memorials for your approval, sir.

(The motion was seconded.)

President Norton: You have heard the report of Dr. Ulmer, with the change in the intern resolution. It has been regularly moved and seconded that this report now as a whole concerning emeritus membership, Woman's Auxiliary, Public Health Week, the New Jersey Plan, the interns and the opposition to S-2008 be adopted. Any discussion?

Dr. Robie: I merely move that the last one be considered separately. I think it is so entirely different.

President Norton: All right.

Dr. Purcell: Why does the Committee feel that a two-year internship will get interns to some of our hospitals when at the present time we are having difficulty getting them for one year? Our smaller hospitals are having a terrible job today getting a one year internship. To make it a two-year internship perhaps will make it still harder for them to get experience.

Dr. Robie: We are hearing nothing but complaints about how long it takes to make a doctor. I think we should definitely vote it down.

President Norton: This is a recommendation to the Delegates to the A.M.A. and this is not binding. This is a direction from this House of Delegates as a matter of guidance to the A.M.A. delegates. You can depend upon them using whatever good sense they have in shifting their base when they get out there. Ths is just an approach to the thing. This doesn't bind them and this doesn't mean they are going to get what they are looking for. They might get something that they are not looking for. Is there further discussion? With the exception of the question of the Physicians Post opposition to S-2008, which will be considered separately, all in favor of the report indicate by saying "Aye"; contrary minded. So ordered.

We will now consider the last item in the report.

Dr. Ulmer: Which was resolution from the Physicians Post 445 of the American Legion opposing S-2008.

Dr. Yaguda: I move its adoption.

(The motion was seconded.)

President Norton: Further discussion? All in favor of the House being on record in opposition to this S-2008 indicate by saying "Aye"; contrary minded. The "Ayes" have it.

Dr. Schaaf: Dr. Norton, Members of the House of Delegates: When I spoke to you yesterday I was enthusiastic about the public reception which had been given to the New Jersey Plan by the press. Some of you thought

I was over-enthusiastic because I was maybe a gentleman-in-waiting at the birth of a royal child. I was not the accoucheur but I was the gentleman-in-waiting. Others thought that I was indulging in rhetorical hyperbole; others thought it was plain malarky, but I am here to give you the McCoy.

I read from the Newark Evening *News* of May 23, 1950, I assure you that no member of the Society did or could have inspired this editorial that emanated from the editorial staff of the Newark Evening *News* spontaneously. I present it to emphasize the position which the New Jersey Plan has assumed on the national scene and it gives the reason this Society feels that it should urge on the Medical Association the adoption of the New Jersey Plan or something very like it. It is the lead editorial in last night's *News*. It is entitled "Medical Care Problem".

The American Medical Association should be in no doubt as to the probable consequences should its House of Delegates fail to offer a practical solution of the medical care problem at its San Francisco meeting next month. The House's action may well be the determining factor in whether this country is to have a national system on a voluntary basis or be faced with the Truman Administration's compulsory insurance scheme with all its disturbing political and economic implications.

A large segment of the public that feels as apprehensive about the Truman plan as do the great majority of doctors has been disappointed by the failure of the A.M.A. to present an acceptable alternative voluntary plan. More than that, A.M.A.'s tactics at times have lessened confidence in it and played directly into the hands of vote-seeking politicians with their empty promises of "free" medical care.

In a matter of such importance to the national interest there has also been a lamentable lack of initiative by state medical organizations. It is significant that the only detailed plan offered for a national health and medical care system on a voluntary cooperative basis is that put forward last February by The Medical Society of New Jersey. In basic purpose and principle it goes right to the heart of the problem.

As between such a program and a government-controled system with its multimillion commitments there should be no question of a choice. Yet the medical oligarchy is reported to be unfavorably impressed, the seeming "defect" being that the program recognizes there are areas of medical care in which "government (Federal and state) may beneficiently cooperate".

This has been A.M.A.'s traditional attitude. The New Jersey society, which is meeting in Atlantic City, should be able to show the attitude is unrealistic and self-defeating.

Dr. Schaaf then moved that this editorial be included in the official record of the meeting, and on being duly seconded, the motion was passed unanimously.

Dr. MacArt: This "New Jersey Plan" has been approved by our Trustees. Was it ever approved by this House of Delegates? Or did we simply approve the publishing of the Newark *News* editorial?

President Norton: No. In Dr. Ulmer's report that was one of the items that we approved; that we are on record as approving the Plan.

Dr. Robie: In view of the comments just made, I think this body should also understand that even if they have approved it without thinking about it further, specific objections to this Plan, good as it is in most features, have been voiced by the economists of the Fighters for Freedom group. This is the group that is working the hardest to spread the book *The Road Ahead* throughout this country. It helped to defeat Senator Pepper. I think we ought to consider what they are saying and perhaps amend our plan a bit.

President Norton: The Chair is conscious of the criticism of the plan and the sources from which the criticism emanates.

We are now down to unfinished business. Is there any unfinished business?

Secretary Greifinger: 1950 scientific exhibits, Class 1, for original work and excellence of presentation, First Prize has been awarded to "Congenital Heart Disease, Diagnosis and Treatment", by Harrold A. Murray, M.D., William Rumsey, M.D., Charles Bailey, M.D., Daniel F. Downing, M.D., Pediatric Department, St. Michael's Hospital, Newark.

Second Prize: "Blood Volume in Surgery", by C. Abbott Beling, M.D., William G. Bernhard, M.D., George L. Erdman, M.D., Donald T. Bosch, M.D., Thomas V. Morton, Jr., M.D., Robert I. Siegel, M.D., Ladislav Stefan, M.D., Eleanor Bonner, B.A., Hospital of St. Barnabas, Newark.

Third Prize: "Fate of Human Tissue Grafts Transplanted in Humans", by Lyndon A. Peer, M.D., and John C. Walker, M.D., Newark.

Honorable Mention: "Constrictive Pericarditis", by Henry A. Brodkin, M.D., and Marvin C. Becker, M.D., Beth Israel Hospital, Newark.

In Class 2, for excellence of presentation—First Prize: "Liver Hyperglycemia and Glycosuria", by Carroll M. Leevy, M.D., Jacob C. Fineberg, M.D., Thomas J. White, M.D., Angelo M. Gnassi, M.D., Medical Center, Jersey City.

Second Prize: "Diseases of the Anus, Rectum and Sigmoid, Diagnosis and Treatment", by Edwin H. Albano, M.D., and Arthur Giffoniello, M.D., Columbus Hospital, Newark.

Third Prize: "Lesions of the Endocrine System", by Samuel A. Goldberg, M.D., Presbyterian Hospital, Newark.

Honorable Mention: "Cytologic Diagnosis", by Nicholas M. Alter, M.D., R. Chesley, Edward Sattenspiel, M.D., W. Berkhofer, F. Traugott, Margaret Hague Maternity Hospital, Jersey City.

President Norton: That is the report of the Scientific Exhibit Committee.

(Motion was made, seconded and passed, that the report be adopted.)

May I now have one very short moment on my own to say thanks to the many members of the Reference Committees, who attended to their duties last night. The Reference Committee attendance by the members of the Reference Committees themselves was rather extraordinary. Many of them had a full quota of their members there.

And then to the House and to The Medical Society of New Jersey a very short word, to you and to all of them to tell you how very much I enjoyed my job last year.

This time a year ago I told you that I recognized it probably as the highest honor that came to me. There is no "probably" about it; it is; it was. And I was deeply conscious throughout the year of my responsibility of representing not only medicine but trying to interpret to the people and the people to us what our mutual problems were. It was not a one-man job.

In my annual report I gave credit to everybody who assisted me—the staff in the front office in Trenton, Mrs. Madden, to Mr. Bryan, to the many committees and to the numberless people throughout the State Society who by word of mouth and many other manifestations indicated that I had their support and confidence.

I don't believe that anybody can function as the President of this Society without Mrs. Madden and Mr. Bryan in these days. You don't know what a bulwark of strength you have in your Board of Trustees. They have been most loyal; they have been highly critical at times of many things that were done, objectively critical, and the end result of the year's work reflects a tremendous amount of time and effort and thought that they have given to the whole program of The Medical Society of New Jersey.

Words now fail me and I confess to a rather embarrassing inadequacy when I try to search for something to say to express to you how grateful I am to all of you for the honor you have conferred upon me, for the tremendous support and loyalty you gave me, and for the urging on in this whole campaign that we have been involved in for the last year. Without it no one could have even started, and having started no one would have been able to accomplish anything. So don't, I beg you, don't get the idea that I think I myself accomplished much. I myself accomplished very little. You did it and more particularly your Board of Trustees did it; and in doing it, it sort of makes me look pretty good, but I assure you that with all the humility that I think one should have at a time like this, I admit readily that I alone would have been unable to do much without the multiple manifestations of the finest of support from our lay employees and from our own professional personnel, again quite particularly our Board of Trustees who put up with me—and I mean put up with me because many times I harangued them and I know I harrassed them—and it was only calling upon a tremendous amount of indulgence that they really did indulge me, and thank you all for a very, very enjoyable year.

(The members arose and applauded.)

President Norton: And now it is my happy privilege to ask Dr. Hilton Read to come up and to present, if one needs to present—this is one of the amenities and the protocol that one must observe, to have presented to you and introduced to you your President for next year, Dr. Aldrich Crowe.

Dr. Read: One hundred and eighty-four years ago a scant handful of far-sighted New Jersey physicians banded together in this country's first state medical society. Its leaders have always been youthful philosophically and biologically quite often, too. Its leadership has been vigorous, liberal and progressive. At least within my memory the presidency has not often been passed around politically or for reasons of compromise, expediency or friendship.

Today as we induct a new President we increase the luster of the Presidency. Aldrich Crowe, a distinguished clinician of Ocean City, a Fellow of the Philadelphia College of Physicians, and a Fellow of the American College of Physicians, has risen from a private in the ranks of organized medicine to assume command today. For more than a decade he has labored long, fruitfully and unselfishly in the interests of both dispensers and consumers of medical care in this state. The organization of The Medical Society of New Jersey assures superb preparation for the responsibility

of leadership because this inauguration comes after a gestation of four years from second vice-president to President. Today marks, not the climax of his work, but rather the beginning of a sphere of greater influence and usefulness.

We of South Jersey consider it a great privilege of lend-lease to The Medical Society of New Jersey Dr. Aldrich Crowe of Ocean City, President for the year 1950-1951.

(The members arose and applauded.)

President-Elect Crowe: Members of the House of Delegates and Friends: I am appreciative of the high honor you have conferred on me and my county by electing me to the Presidency of The Medical Society of New Jersey. I am also very cognizant of the great responsibilities that go hand in hand with this office. Thank you.

Our Society has been doubly honored this year on a national level, first by the election of Dr. J. F. Norton as Vice-President of the American Medical Association; and second, by having our own Mrs. David B. Allman serve as President of the Woman's Auxiliary of the American Medical Association.

The citizens of this state have been very fortunate in the reelection of Governor Driscoll. He is a man who has never hesitated to take a definite stand opposing the Welfare State and compulsory health insurance. Therefore, it is appropriate that we should take this opportunity to express our thanks to him and our approval of his actions.

Again New Jersey is quite fortunate in its Congressional representation. We have most of our congressmen working along with Senators Smith and Hendrickson to fight the battle against compulsory health insurance. May I suggest that you read some of the statements these men have made on this vital subject? And may I also suggest that you, as individuals, give serious thought to this coming November election? It is a crucial one as far as the medical profession is concerned.

Now for the coming year and some of the things I hope to see accomplished. First, last and always there will be no easing in the fight against compulsory health insurance. The Woman's Auxiliary have been a tremendous factor in our educational program and, if possible, I'd like to see this educational program expanded. Just as a mere suggestion, I pass on to the physicians that they try to emulate the efforts and accomplishments of the Woman's Auxiliary in this work.

Due to the compulsory health insurance battle, other vital activities of the Society have necessarily been overshadowed. Under this head comes the Welfare Committee. It is time now that this committee and its important subcommittees take their proper places in the sun.

In order that you, as individual physicians, may know more of state society activities, the junior officers and councilors will, from time to time, visit your county societies to discuss your problems and state problems. This will naturally result in a closer liaison between the state and county organizations. As your President, I hope to make each individual member of our society feel that this society is his own and to it he owes a responsibility.

Again thanks to you and my promise to you that the keynote of this next year will be consultation and cooperation. (Applause)

Dr. Purcell: There seems to be a little confusion in the minds of some of us about this intern situation. When we voted there seemed to be a little bit of misunderstanding with some of us, including myself, as to whether we voted that this committee shall ask the A.M.A. to go on with a two-year program or whether they shall just ask to go on with the program of allocation of interns.

President Norton: Both.

Dr. Purcell: Well, now, may I speak just a moment on that situation?

President Norton: You will have to ask for reconsideration of the action of that Reference Committee.

Dr. Purcell: Well, I move then a reconsideration of the action of the Reference Committee.

(The motion was seconded.)

President Norton: I will put the question. The question is for a reconsideration of the action of the Reference Committee that brought in the report on the intern problem. All in favor of reconsidering signify by saying "Aye"; contrary minded "No" the Noes have it; the motion is lost.

Dr. Allman: Mr. President, if there is no further business, I move that this House give you a rising vote of thanks and then adjourn.

(The motion was seconded.)

President Norton: The final action, and I have to put the motion of Dr. Allman's, and I will incorporate it in one motion, a rising vote of thanks, not to me, but to the President of The Medical Society of New Jersey.

The rising vote of thanks was approved, and the members arose and applauded.

Motion for adjournment was then made, seconded and carried. At 4:25 p. m., the 184th session of the House of Delegates adjourned *sine die*.

GENERAL SESSION

May 23, 1950

The General Session of the 184th Annual Meeting of The Medical Society of New Jersey convened in Haddon Hall, Atlantic City, N. J., at 2:15 p. m., Dr. James F. Norton, President of the Society, presiding.

President Norton: Dr. Bauer, Ladies and Gentlemen: As President of The Medical Society of New Jersey, I welcome you here to this general session and I hope that the talks of the afternoon will do something to clarify the overall approach of the medical profession in this country to meet the needs of a national health program.

I have the distinction of presenting to you this afternoon, as our first speaker, the Chairman of the Board of Trustees of the American Medical Association. In this day and in these times I doubt whether anyone, except those intimately identified with the affairs of medicine, have any concept of the amount of time that the officers and those dedicating themselves to the cause of preserving for us the private practice of medicine that we know—I doubt if anyone has any idea of the sacrifices that the officers of the national organization and the various state organizations are called upon to make.

When you think that a man like Dr. Bauer, in addition to being Chairman of the Board of Trustees of the American Medical Association must also keep up with his private practice and keep track of his patients and care for them, you wonder how he divides himself into so many parts and into so many places so many times and so effectively and so efficiently.

It is an honor, distinction and a pleasure to present to you, therefore, the Chairman of the Board of Trustees of the American Medical Association, Louis H. Bauer, of Hempstead, Long Island. Dr. Bauer. (Applause)

Dr. Louis H. Bauer: Mr. President, Ladies and Gentlemen: I consider it a privilege to be here today. This is a pleasant performance for me. I was talking with Dr. Londrigan shortly before I came here this afternoon and recalled to him that I spoke to your House of Delegates in 1944 when he was the incoming President. At that time, I was Chairman of the newly created Council on Medical Service of the American Medical Association.

Two weeks ago, your President and I were together in a forum in New York. I was delighted to be in the forum with him, but I am afraid the delight stopped about there, because the forum wasn't too pleasant. I think there were those who thought they would put us over a barrel. Well, I don't know how Dr. Norton feels about it, but I can assure you they had considerable difficulty in putting him over one. (Laughter)

It appears now that there is little chance of any enactment of compulsory health insurance by this Congress; in fact, the tactics of our opponents have changed. They are no longer trying to push this bill. They are endeavoring to enact certain fringe bills; that is, they want to nibble a little bit off here and a little bit off there in the hope that eventually they can get their whole program enacted bit by bit. We must be on guard against any such tactics.

It seems likely, too, that the issue of compulsory health insurance will be dragged into the Congressional election campaign this fall. Medical societies as such and doctors as members of medical societies cannot engage in political action. Doctors as citizens can and should. How a person votes is his own business, but it is the business of a free America to see that he registers and votes.

Doctors in many parts of the country have been woefully lacking in their civic responsibilities in this respect. In some areas, only twenty-three per cent of the doctors have voted. I don't know what your record is here in New Jersey, but I know that it is nothing to be proud of in my own state. You can all do your part as good citizens by seeing to it that you and all eligible members of your families register and vote. How you vote is a matter between you and your consciences.

That doctors are effective campaigners was recently evidenced in Florida. Most of those who are in the know in the Florida situation give great credit to the doctors, as individuals, for the way that primary went in Florida earlier this month; and if it was done there, it can be done again.

Emphasis in our own campaign this year is going to be constructive rather than just that of opposition. During the past year we have been too busy putting out the fire in our own house to think very much about constructive action. Now, however, the fire has been brought under control and we must build for the future. But bear in mind that we have simply won a breathing space and that is all.

Our voluntary insurance program has been

going very well indeed, but it has three very definite gaps which must be bridged. *First,* we must push individual enrollment rather than group enrollment, and that is gradually coming about. Most of the plans now are accepting individuals as well as groups. *Second,* we must push protection for those over sixty-five years of age. Until recently, most of the plans have let people out when they were sixty-five, at the time when they needed protection most. And this change, too, is gradually being accomplished. Most of the plans now are protecting people, once they are insured, as long as they live. *Third,* we must provide a policy against financially catastrophic illness. It can be done along the lines of an automobile deductible policy. Most of you on your automobiles carry collision insurance, but I doubt if many of you carry full coverage. Most of you probably carry fifty or a hundred dollars deductible. If there is any damage to your car up to fifty dollars, you pay for it. If it is above that, you are protected. And we want an insurance policy for health along the same line. That is, up to a certain limit the individual will pay; above that he will be protected.

The California Physicians' Service has announced such a policy within the last two months and we hope before the end of the year that there will be several others. Our aim must be to see that all non-profit and commercial companies give us such policies so that we will have the whole country covered within the next two or three years. When these three gaps are filled we shall have largely solved the insurance problem.

We must continue to back the program of local health units so that the country will be covered by proper public health service, so as to prevent as much disease as possible. Nearly half of the country at present has only inadequate public health coverage or, in some places, none at all. For instance, there are some 2500 incorporated communities involving twenty-five million people that have no sewer facilities whatever, just as one example. Public health authorities say that with 1200 units they can cover the whole country. Everybody agrees that that is something that should be done; yet legislation to make it operative still has not been enacted.

We must also cooperate in carrying out the provisions of the Hill-Burton program to afford facilities for diagnosis and treatment for areas that are now lacking them. It will help people in those areas by bringing facilities closer, thereby making it unnecessary for them either to go without them or to travel long distances to get them. And it will attract doctors to those areas. Doctors will not settle in areas where they cannot practice good medicine, and you can't expect them to. Under present conditions, training additional doctors will result in their settling in the cities where they are not needed. Kansas has solved the problem by furnishing facilities for doctors in rural areas. They have had no difficulty in getting practitioners to go there.

There has been a good deal of propaganda about our needing thousands more doctors. The facts are these: we now have more medical practitioners in proportion to population than any country in the world. Our nearest competitor is Great Britain. In the United States we have one doctor to every 700 persons. In Great Britain they have one to a thousand. But we do not have equitable distribution of those doctors. In New York City there is one doctor to every 450 persons; in some of the rural counties in Mississippi, there is one to 1800.

We also need more doctors in the fields of public health, psychiatry and pathology. The ratio of doctors to the population is increasing faster than the population.

Dr. Willard C. Rappelye has compiled the following statistics: From 1937 to 1942, 25,818 doctors graduated and only 18,898 died. This gave an increase of 6,920. From 1942 to 1947, 32,877 doctors graduated and 16,455 died. This gave an increase of 16,442. That was the period when the accelerated medical training program was in effect. In the following year, 6,855 graduated and 3,575 died, or an increase of 3,280. And in the following year, 6,597 graduated and 3,230 died or an increase of 3,367. These increases are startling in view of all we have heard about the subject and they do not take into account newly established medical schools. To increase any further the enrollment in our medical schools will lower the standards of medical education, as schools are now operating to capacity.

One other problem is a program for the indigent. I am not familiar with your program in New Jersey, but doubtless it is similar to those in New York and Pennsylvania which are most satisfactory; such systems should be operating over the whole country. The indigent are a local responsibility and must be handled as such. They do not appear to be an insurable risk.

We are all working to the same end and there is more unity in the medical profession today than there has ever been in its history. We are going to win the battle for the free-

dom of medicine and for the protection of the public against this "get rich quick" promise of inferior medical care that is being handed out by Oscar Ewing and his associates.

There is no question but what our program needs amending. It will always need amending. In medicine we never reach our goal. When Dr. Lee was installed as President of the American Medical Association, he made a remark which impressed me very much. He said: "We never reach our goal because as we approach it we are constantly pushing our goal farther away. In other words, we set our sights higher and higher all the time."

No program will ever be perfect, but we can strive for one which will approach the ideal of perfection. And I am sure that we are going to attain it and I am sure that the public has become so thoroughly aroused now that they are not going to accept substitutes which in the long run will result in their having an inferior type of medical care. We are all working to that same end and I am in hopes that within the next year we shall see definite progress towards attaining the objectives, some of which we have already reached.

I appreciate the opportunity of coming down and paying tribute to Dr. Norton, whom I think you are exceedingly fortunate to have as your President. Thank you. (Applause)

President Norton: Thank you, Dr. Bauer.

We have in New Jersey been very, very active, as I guess now most everybody knows, in aiding the cause of medicine in this country. We have one particular example of it, which I would like to bring to your attention today, of which we in New Jersey are particularly proud.

We have been told for a long time and we have come now to realize it as an integral part of our overall campaign to bring to the attention of America what American medicine stands for, the importance of the Woman's Auxiliary. The Woman's Auxiliary is not like Topsey. It didn't just grow up. In this state it became great, it became influential, it became prosperous, it became a very real, vital, breathing part of The Medical Society of New Jersey through the leadership of many of the very fine women who have headed its organization throughout the years. Currently New Jersey is highly honored by having one of its own members, the wife of one our own doctors, presiding over the destinies of The Woman's Auxiliary to the American Medical Association.

We have here in New Jersey the National President of the Woman's Auxiliary, a fine, a lovable and charming lady, but with it all, an individual who has really produced something, who has gone down into the market place and who has met the people and whose understanding of the people's problems has brought to the medical profession of this state and to the medical profession of the country as a whole a goodly bit of honor and prestige and dignity. I would like the lady to take a bow. Mrs. David Allman. (Applause)

Quickly I would like to say a few words now.

I don't know what kind of a barrel they tried to put me over, Louis, but physically they'd have a hard job putting me over any kind of a barrel, I think. (Laughter) I am too rotund to go over a barrel. In New Jersey, we have been very seriously concerned about implementing an aggressive, articulate overall health program and we proposed on January 30th a plan motivated by a number of urgent considerations; first by a desire to respond to the public demand for medical leadership. The program represents an effort also to satisfy repeated requests from our own legislators national and state, for a clearcut statement of what the medical profession stands for and what, specifically, we propose to do to accomplish our objectives. These proposals were further motivated by an overwhelming sense of the need for a closer working relationship between the medical profession and the voluntary insurance plans for hospital and medical care, many of which were in fact created by the medical profession.

Dr. Bauer today pointed up three gaps that must be bridged to meet the demand. He speaks first of the need for individual enrollment. That is something we have in New Jersey. We need care for those who are over sixty-five years of age. We need to make it possible for people to meet those conditions called financially catastrophic illnesses. He speaks, too, of an increase in local health units. Every one of these points we have covered, we have detailed, we have called attention to in our own program which we have promulgated on January 30th in Newark.

Finally, our proposals are designed to spell out a detailed program for accomplishing the broad objectives set forth in the twelve-point National Health Program of the American Medical Association, which was promulgated in February 1949, and which, I have some reason to believe, will be broadened in San Francisco in June 1950. Among those twelve points there is this one: The American Medical Association emphasizes that there is need for further development and wider coverage

by voluntary hospital and medical care plans to meet the cost of illness with extension as rapidly as possible into rural areas; aid through the states to the indigent or medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

Hoping, almost praying that we would meet more specifically the aims of the American Medical Association, we embarked on this program. We are one with the American Medical Association and we *are* the American Medical Association. We are as much of the American Medical Association as any other state society in this country. We see eye to eye with the American Medical Association that there shall not be, there must not be, there will not be government control of the practice of medicine in this country.

We see with the American Medical Association that there is a need to be met and we say to the American Medical Association that we think we have an idea and we ask them only to listen to us. It is unlikely that they will accept all that we say, but in sympathy with them and with a heart beating in unison with theirs, we speak up and say to America that the doctors know what to do, they know what the answer is, and they now propose, in their own right, some answers.

No longer do we think it should be necessary for us to go out and say that we are against compulsory health insurance for many valid and convincing reasons. Now is the time when we can go to the people of this country and say we are for voluntary health insurance in this manner, under these auspices, in this respect and to this extent; the time is here, it is now at hand, the hour is here, and if we take a theme song we can sing it. Now is the hour to tell the people of this country that American Medicine knows it, American Medicine realizes and American Medicine is now willing to practice that kind of approach to meet the economic needs of the people of this country to meet their health costs.

I can turn the clock back but a short thirteen months ago when I assumed the presidency of this Society. I said here, standing on this platform, that we agree that there is need for cohesive action concerning the national health program. We agree with the President of the United States that it is an important problem, and we most heartily agree with our parent organization, the American Medical Association that there should be a well delineated, sharply defined, well articulated, forceful national health program for these United States. We have the answer if only we can learn to use it, to apply it to its maximum. We must use it, we must effect a more widespread dissemination of all the voluntary plans. That was in April 1949.

This, gentlemen, has been our unswerving aim and purpose: to unlock the energies, to stimulate the imagination and to inspire the determination of doctors and laymen alike to solve our mutual problems through voluntary cooperative action. We have endeavored to wage a *positive* battle, to accentuate the positive, and to eliminate the negative.

The proposal of The Medical Society of New Jersey for a national health care program represents probably the first comprehensive effort on the part of any medical society in the United States to present a detailed, specific plan of action for developing, improving and expanding voluntary health insurance plans adequately to meet the needs of the people of the United States for medical security.

Every solution proposed on a national scale by members of Congress or by the present National Administration involved to a greater or lesser degree the ultimate, if not the immediate, control of medical service by the federal government. Every solution of this type so far proposed will lead inevitably to a monopolistic control of the practice of medicine by the federal goverment and to a rapid loss or destruction of those elements of private initiative and personal responsibility which have enabled the American doctor to develop his art and science to the point where today he is the envy of the whole world.

We in New Jersey are profoundly convinced (and the public response accorded our proposals thus far affirms our conviction) that the people emphatically prefer a voluntary approach as against any resort to government compulsion; provided only that the voluntary program will meet the recognized social needs of the people.

We are talking about the general common good and not the particular specific good of you or me as a doctor. Accordingly, our effort is to respond to the public demand for constructive, definitive medical leadership and to offer a realistic solution to the problems confronting us as citizens and as doctors.

The Medical Society of New Jersey believes that the time has arrived when we must particularize and spell out in detail precisely how we propose to obtain the widest possible coverage for voluntary insurance plans especially for the low, the lower and the lowest income groups who most need such plans.

To carry out this objective, we have, in general, invoked the sound principle of subsidiary aid, in terms that will assure that such aid is, in fact, subsidiary; but is, nevertheless, substantial.

We begin by acknowledging and applauding the growing tendency of private employers to aid their employees by paying part or all of the cost of membership in approved voluntary health insurance plans. The federal government has acknowledged the value of such private subsidies by compensating employers for these contributions, permitting them generally to claim deduction for such expenses in calculating their corporate income taxes. If government can do this for the employer who aids his employees in purchasing such insurance, why should not goverment also extend tax deduction to the individual who purchases nonprofit insurance for himself out of his own pocket? This, in fact, is our first proposal.

Next we urge that government at all levels, as an employer, should assume part or all of the cost of such plans for its own workers, by direct aid to the worker, not by subsidy to the plan.

A further proposal is that state and local governments purchase voluntary insurance for the medically indigent, for whose medical care state and local governments already have an acknowledged responsibility.

In the last issue of *Readers Digest,* the President-Elect of the American Medical Association underscored the validity of the principle of government subsidy for the care of the indigent. Maybe we are nearer to an understanding than we were six months ago.

For those on public assistance rolls and the chronically ill, we suggest the possibility of utilizing the voluntary hospital and medical care plans on a cost basis. These plans provide the mechanics for supervising the medical service program.

Two points in the New Jersey proposals bear on the need of "improving the product", of liberalizing, extending and making more attractive the medical service plans themselves.

The New Jersey proposals include specific suggestions for improving local public health services, and you have just heard from the Chairman of the Board of Trustees of the American Medical Association that they consider that to be a prime objective in the overall national health program. We think, too, that our proposals include specific suggestions for providing hospital facilities and physicians for sparsely populated areas, and for increasing the production of physicians, health officers, and nurses. If citizens, acting individually or through such voluntary associations as Blue Cross—Blue Shield, will directly meet their social responsibilities, we may then rightly demand that government stay in its proper place as the servant and not the master of the people. It is not yet too late for the responsible citizens of a free society to put government in its place and to keep it there.

The delegates of our Society to the House of Delegates of the American Medical Association will present this program for national consideration next month in San Francisco. We then hope that what began a few months ago as a modest "New Jersey Plan" may possibly become an "All-American Plan".

We believe most earnestly that the state, if it takes over, will exercise coercion. We believe that when the individual exercises his right, he does it of his own volition. The state is but one among numerous institutions which make up society and it should be called upon only to perform those functions that private individuals or private agencies cannot do. But as long as private individuals or private agencies can meet their own individual private rights and responsibilities, that government has no right to come in and usurp those rights from the individual.

We believe the solution to the problem of the nation's health does not exceed the powers of individual or group action. There exists today no valid reason, no justifiable demand for the intervention of government. American Medicine, I am sure, I am confident, I am absolutely certain, can provide the leadership. We have a splendid corps; we have everything which should add up to a certain absolute victory if only we know how to go about it, if only we can unlock the energies, if only we can provide the leadership.

People—and I have talked to many of them—do not want compulsory health insurance. People want one thing: they want their health needs taken care of. They much prefer to have it done on a voluntary basis. We have an opportunity to tell them how we think it should be done and we have promulgated a plan which we think spells out how it should be done.

If American Medicine misses this opportunity and if that need still remains unsolved, there is no alternative—not only has the government a right to come in, it is imperative that the government come in because the overall good, the common good of the community is the thing that must and will be served.

We must pray—seriously I mean it—we must pray and pray earnestly that the leader-

ship of American Medicine in the next few months will be able to interpret accurately the needs of the people and to offer to the people an understanding program which will meet their needs and which will forever, not 1950, not 1951, but forever, deny the need that government must come in and take over. Thank you very much. (Applause)

The next speaker is a man known to most of you, who, I hate to say, is doubling in brass for his Excellency the Governor of New Jersey. I had a note from the Governor to the effect that Dr. Bergsma would represent him here today. But Dr. Bergsma can come to us in his own right; he needs not come to us as doubling in brass for anybody. He is a public health officer, pre-eminently qualified for his position, nationally known, who is doing a splendid job here in New Jersey.

Existing between the Department of Health in New Jersey and The Medical Society of New Jersey there has been, since Dr. Bergsma came here, a very close, a very cordial and a very happy relationship. We in medicine in New Jersey could not wish to have a more cooperative health officer than we have had in Dr. Bergsma. It is a pleasure and an honor to present to you Dr. Daniel Bergsma, Commissioner of Health of the state of New Jersey. (Applause)

Dr. Daniel Bergsma: Thank you, Mr. Chairman.

Ladies and Gentlemen: I am pleased to have the opportunity to speak to you on the subject of public health and medical practice because if we are to work toward the maximum positive health of which our citizens are capable, we must continue to develop an ever closer relationship between the medical practitioners of individual health and of public health.

There is no rigid line to mark the point at which public health efforts end and the efforts of private practitioners begin. The reason for this is clear: public health departments perform those functions which the public stipulates that they shall perform. The scope of work of a public health department is imposed by law and by the administrator's understanding of the law as he strives to carry it out.

At its meeting in St. Louis in 1948, the House of Delegates of the American Medical Association defined public health in these words:

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts.

"It includes those arrangements whereby the community provides medical service for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community and with the medically indigent."

Dr. Harry S. Mustard in his book, *Government in Public Health,* put it this way:

"The general trend is to consider that a health program becomes a public health one when, because of its nature or extent, it may be solved only by systematized social action. . . The real question at issue is not so much whether the person is well or ill, or even, in the last analysis, whether rich or poor—for the rich use the sewerage system—but rather when, or if, a given problem of health and disease can no longer be solved by the unassisted effort of the citizen and the uncoordinated resources of the community."

The promotion of human health requires effective teamwork. Members of the team include the general practitioner, the specialist, the hospital, the health department, the pharmacist, the nurse, and the voluntary organization. Each member of the team should look upon the other as an indispensable colleague.

In a state health department, many of the personnel must be trained not only in medicine but also in public health. We believe that any person holding a position requiring medical knowledge and judgment must be a physician licensed to practice medicine in the state. One of our objectives is to have physicians who are well trained and experienced specialists on our staff. We feel that our staff should represent consultants to and not competitors of the private practitioners of medicine in the communities. Increasingly, we are achieving these goals.

A recent announcement of the World Health Organization states that more than three-fourths of the world's population are victims of diseases resulting from poor sewage disposal, unsafe water supply, insects, and inadequate protection of milk and food. Although these conditions are not responsible for the same proportion of deaths among residents of the United States, the statement nevertheless reflects the importance of preventive control measures which make up an important part of the work of public health agencies.

Some persons have advocated that health departments take over all functions relating to health in the community, including public medical care. Public health men who oppose this extension of authority argue that the very important preventive and educational work which is properly within their sphere will be submerged by the use of their resources for the more costly therapeutic services.

Dr. Wade Hampton Frost, celebrated epidemiologist has written: "The activities embraced within the scope of present day public health work are so extensive and diversified that the health officer's task would be sufficiently difficult if he had only to organize and direct the work along lines already laid down which define the scope and distribution." If a line of activity is imposed upon a health officer by law he must of course try to carry out the intent of the law. But before recommending new lines of activity suggested by changing conditions or urged upon him by special interests, it is the duty of the health officer to consider what returns are to be expected from each, how much of his resources he shall put into each, and whether the returns will justify the expenditure. Public health departments should perform a minimum of six basic services. These include the collection of vital statistics; the maintenance of certain laboratory services; the control of environmental sanitation; the control of preventable diseases; promotion of maternal, child and adult health; and health education. The last named, health education, is essential to attainment of success in the other five.

It is now generally accepted that control of preventable diseases is a public health function. Case-finding is one of the devices of such control. In April of this year there was a "Cavalcade of Progress" at Asbury Park. There was a booth at this Cavalcade at which the public was invited to have chest x-rays taken. Several hundred persons availed themselves of this opportunity. Reading of the x-rays indicated that 55 should have medical attention, 42 for what appeared to be possible tuberculosis, and 13 for what seemed to be cardiac involvement. Each of these persons was asked to see his family physician for further study. There have been many such case-finding projects. They find pathology which might not otherwise be found until the symptoms were pronounced enough to motivate the patient to go to a doctor. The consequences of such delay to the individual are obvious and the hazard to public health from the presence of a spreader of tuberculosis is also obvious. The screening project is therefore illustrative of the partnership which must prevail between the health department, which screens the population and finds the cases, and the practicing physician, who completes the diagnosis and treats the patients.

Few quarrel with the idea that screening for a communicable disease such as tuberculosis is a logical public health function. Some physicians have had reservations about the propriety of public health departments looking for undiscovered cases of ailments which are not communicable. I think almost all physicians will agree that several chronic illnesses, because of their social and economic effects, have already attained the proportions of a public problem as well as a health problem. The problem has become so important that last year the Legislature resolved to have the Governor appoint a committee to inquire into chronic illness and what can be done about it. This committee, which includes medical, nursing, hospital and citizen representation, is now making studies and holding hearings prior to rendering its report. We physicians know that one of the things that can be done about chronic illness is to detect as early as possible those conditions which can be cured or partly alleviated and which lead to chronic illness if neglected. The only practical means of locating a reasonably high proportion of the potentially crippling conditions, during the very early clinical or preclinical stages, is by effective use of mass screening of presumptively well persons. Screening projects have not competed with private physicians. They have done just the opposite; they have greatly augmented the number of patients referred to private physicians.

Last year your State Department of Health urged 7664 citizens to go to their private physicians for final diagnosis and treatment as necessary. These include suspected cases of pulmonary tuberculosis, heart disease, cancer and other pathology of the thoracic area and diabetes mellitus.

Although this is the beginning of the second quarter-century since the discovery of insulin, the problem of diabetes still looms large. In addition to the million Americans who have diabetes and who are under treatment and control, there are another million persons who have diabetes but who do not know it and who are not receiving medical care and whose condition is becoming progressively worse because they do not know they need medical care and hence do not seek it.

Screening methods used in the past have not been as efficient as they could be. Refinements in methods can be made which will yield more specific results or which will produce a greater number of positive findings per thousand cases surveyed. In our venereal disease control program, for example, we took note of the fact that a larger number of cases existed in some districts than others. By directing our case-finding to such areas, we of course turned up more positive reactors than by non-selective screening of the general population.

We now propose to make a similar approach in screening for tuberculosis. Our statisticians in the State Department of Health have been plotting in detail the locations of concentrations of new cases of and deaths from tuberculosis in 1949. Using this information, we can make efforts to screen people in these particular areas. It is logical to believe that this type of selective screening will yield more positive cases in proportion to the number screened than the screening of general population groups. We shall be discovering more tuberculosis in proportion to the money expended and we are hopeful that more cases can be brought under treatment, thereby reducing the spread of the disease. In some states, tuberculosis is no longer one of the ten leading causes of death. It ranked fourth in New Jersey in 1949. There seems to be no reason why a state with the wealth and the physicians and the facilities that New Jersey has should not be able to bring down the incidence and death rates from tuberculosis to a more reasonable level.

Another benefit to physicians is derived from these tuberculosis statistics. By locating areas in which tuberculosis is most prevalent, we can alert the local physicians. If a doctor's home or office is in an area in which the incidence of tuberculosis is higher than average, it seems to me that he would like to know about it. He should like to know about it so that he will be more prone to search for tuberculosis among the patients who come to him for respiratory or other conditions. He should like to know about it also for his own protection and the protection of his staff and family. Tuberculosis is one of the serious health hazards to physicians and nurses.

The gathering and use of statistics thus afford another illustration of the team concept about which I have been talking. The health department by its very nature and function is able to locate certain hazards which the individual physician cannot locate by himself. Alerting the physician to hazards is an aid and protection to him.

This was illustrated in another way a little over a week ago. At that time the Federal Food and Drug Administration learned that the formula of a marketed drug, Oxylin, had been changed and that a dangerous amount of boric acid had been added. Thousands of these tablets had been marketed before the hazard was detected and New Jersey was a part of the market area. Whenever such events occur, the State Department of Health goes into action as part of a team. We immediately give a story to the press services so that the newspapers can warn everyone. We inform the State Police and they teletype the message to all hospitals in the state. The New Jersey Pharmaceutical Association alerts every pharmacist in New Jersey, and every state institution likely to use such drugs is informed. This sort of service not only protects the general public; it protects the physician. When the physician prescribes a manufactured drug, he orders that drug on faith. He cannot personally take the time to analyze it to see what it contains. He prescribes it because it has been approved for use for specific purposes. In the instant case, the formula had been changed, unknown to physicians or anyone else. A patient who suffered ill effects from such a prescription would not be likely to blame the manufacturer; he would be inclined to blame either the physician or the druggist. The health department thus not only supplements the work of the other members of the team; it is often in a position to protect them.

Eternal vigilance over purity of foods and drugs; control of water and air pollution, and certain radiologic hazards are other problems with reference to which the private practitioner of medicine must necessarily look to the public health practitioner of medicine for guidance and support. Increasing industrial use of very high voltage x-ray machines and radium or radio-active cobalt to detect flaws in metal castings creates ever-increasing, insidious hazards which can be detected only by special monitoring devices and technically trained personnel. Your public health authorities are providing such preventive services.

Returning to the subject of screenings, there is a drawback to screening for single, specific, abnormal conditions. Our goal should not be to determine solely whether an individual does or does not have a specific illness. It should be to determine whether or not he has the maximum health of which he is capable and, if he does not, how the private practitioner of medicine can help him to attain it.

Perhaps this concept can be further clarified by the following quotation from a report issued in Massachusetts:

> "It is not enough merely to keep our people from dying. We want to augment the life and energy of the people; to accumulate vital force; to impart the robustness and opulence of health, which makes a man vigorous to do and dare noble things, whether it be an artisan at the bench, or merchant at the counting desk, the orator in the rostrum or the statesman at his legislative post; we want *life* as well as long life. We need such productive health as not only makes life endurable but vigorous, so there shall not only be absence of pain, but pleasurable performance of function."

Multiphasic screening or the "One Package Health Test" may be one of the tools which can be used to this end. The discovery of diseases other than tuberculosis in chest x-ray surveys has stimulated interest in the development of other tests that may also be applied to apparently normal persons in the hope of recognizing several other diseases before symptoms have appeared. Persons who consider themselves well are not inclined to go to a physician and ask that he help them to stay well. Those who have participated in organizing community programs also know how difficult it is to educate the public to participate. The effort would pay greater dividends if, instead of individual campaigns for specific diseases, we planned to perform as many screening tests as is feasible at a single visit. With our present knowledge, a blood sample can reveal the probable presence of several diseases. Multiphasic tests are not designed or intended to establish final diagnoses. While some of the tests are sufficiently accurate for the actual diagnosis of disease, the procedure is designed to screen out of a large group of apparently well persons those who presumptively are ill and need additional tests which can be performed by the individual's physician to affirm the presence of disease and to establish the need for proper therapy.

Many persons go to a physician only after an illness has rendered them permanently disabled, economically or physically. The discovery of the same disease at an earlier time might have permitted the individual to maintain his health and his economic security. There is much to be said in favor of an adequate periodic health inventory. It was one of the objectives of organized medicine a few years ago. It is one which organized medicine might well wish to reconsider for promotion. Your State Commissioner of Health would be delighted to have every physician's office a true health promotion center where, in addition to the treatment of disease, serious efforts to promote better health for infants, children, mothers and fathers were a major daily activity.

Multiphasic screening is in line with another concept which has gained acceptance in recent years in both public health and private medical practice. It is the concept of constructive health, the idea that we do not treat an individual merely to cure or alleviate what is wrong with him but that we treat him so that he can enjoy the maximum health of which he is capable. It is a shift in emphasis from the negative, or absence of disease, to the positive, or enhancement of health. This concept is illustrated in the treatment and preventive care which pediatricians give to children and to the advice which they give to their mothers. A child who comes to the pediatrician for a check-up may not be ill. His mother brings him because she wants to keep him well. She therefore wants her child immunized and his physical and mental development checked. It is a good kind of medical care and one that should be advocated for every member of the family and not merely the infant and preschool child. The pediatrician has an ideal opportunity to educate the mother, and to a lesser extent, the child to this concept.

For many years the maternal and child health services of the State Department of Health have stressed the principle of constructive health including anticipatory guidance in the emotional and mental health fields, especially in infants.

The medical profession of this country can be proud of its achievements in the curative and preventive fields of medicine. The knowledge gained by research has been applied to create a new low death rate of ten per thousand and raised the expectation of life to an all-time high of about 66 years.

This improvement has not been general. Reduction in mortality has occurred in the diseases of children and young adults but there has been little improvement in the rates for the degenerative conditions that affect persons in the later half of life. Chronic diseases cause about a million deaths each year and about a billion days of disability. A billion days of disability and unemployment a year are not cheap. Victims of chronic diseases occupy 750,000 hospital beds and receive the equivalent fulltime service of at least one-third of our physicians.

If we want better health for our citizens, we must do something constructive about improving our preventive health services. A part of this team is the local public health unit. While no one is suggesting that local public health services should treat the chronically ill, there is nevertheless a direct relationship between the reduced prevalence of both acute and chronic illness and increased public health services. The control of preventable disease is, for example, a public health function. If we succeed in reducing the morbidity of tuberculosis alone, we shall have made a sizable dent in the chronic disease problem. Effective local public health services raise the whole level of community health. They not only protect the citizenry but they serve the doctors, the nurses and their families as indicated above.

We shall have another opportunity within

the coming year to reorganize our local public health agencies so that they can render more effective service. This is in the direction of extending to the community level the reorganization of public health which was started at the state level. The reorganization of the State Department of Health was accompanied by a significant increase in the output of work. This was achieved by a more functional realignment and more efficient technics. Something of the same character should be done at the local level.

A committee appointed by Governor Driscoll is now studying the problem of local health administration. Medical doctors on the committee include Dr. Samuel Blaugrund and Dr. Roscoe P. Kandle. This committee has, for some time, been hearing testimony by specialists and other interested persons on the need for improved local health services and possible ways of achieving same. Since this committee will advance its own recommendations, it is not my intention to make any specific proposals here. It may, however, be of interest to you to have the problem briefly outlined.

New Jersey has 566 municipalities, of which 60 per cent contain fewer than 2500 citizens each. Not one of these small municipalities can afford a full-time health officer. It might be presumed that the remainng municipalities are all of good size and suitable units for conducting an efficient local health department. Unfortunately, that is not so.

Most authorities accept the figure of 50,000 population as the minimum for economical local health department activities. New Jersey has only 13 cities with populations of 50,000 or more.

Only about 51 per cent of New Jersey's citizens have the benefits of the services of a full-time licensed health officer; 35 per cent of the citizens have no licensed health officer.

On a municipality basis, the picture is even worse. More than 70 per cent of our New Jersey municipalities have no licensed health officer. This should be remedied as soon as possible.

The need is clear. A legally recognized agency is required to enable local municipalities to provide self-administered health services throughout a consolidated multi-municipal jurisdiction on a basis comparable to that now used for highway construction, welfare, and public education.

All Jerseymen need local public health services designed to prevent disease and to enhance positive health.

To accomplish this, we need amendments to existing laws concerning local health administration or new legislation to accomplish the same result.

Because of your daily contact with sick people, you doctors, more than any other group, know of the great need for better local public health services in your respective communities. You and I have a great opportunity to exercise leadership in arousing interest in and support of efforts to accomplish this worthy aim. Our medical knowledge and health awareness place a great responsibility upon each of us to grasp that opportunity and to work for more effective local health departments. Working together as a team, practitioners of medicine, the allied professions, and public health departments can make the health of our New Jersey citizen even better than it now is. (Applause)

President Norton: Dr. Bergsma, for all here present I wish to say thank you very, very much for your very interesting, thought-provoking, and overall challenging talk. Thank you very much.

(The meeting was then adjourned at 3:20 p. m.)

TRANSACTIONS OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTY-THIRD ANNUAL MEETING

The 23d Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall on May 23, 1950. The meeting was called to order by the president, Mrs. Norman Nathanson. The invocation was delivered by the Reverend Harvey Bennett, First Presbyterian Church of Atlantic City. Mrs. Louis Rosenberg, president of the Woman's Auxiliary to the Atlantic County Medical Society gave an address of welcome. Mrs. R. John Cottone, president-elect, delivered a gracious response.

The president introduced Mrs. David B. Allman, president of the Woman's Auxiliary to the American Medical Association, and Mrs. Edgar Byers, a member of the Montgomery county (Pennsylvania) Auxiliary.

Mrs. George A. Rogers, past-president, conducted a memorial service for the following deceased members: Mercer County—Mrs. A. D. Hutchinson, Mrs. E. V. Woodward; Middlesex County—Mrs. M. S. Meinzer; Salem County—Mrs. John S. Dunn.

Mrs. Harry Subin moved that the minutes of the 22d Annual Meeting be approved as printed. Seconded and carried. The treasurer, Mrs. Asher Yaguda, submitted her annual report showing a balance of $1,671.61 in the general fund, $485.63 in the emergency fund, a total of $2,157.24, as well as two series F Bonds, face value $100 each.

The second vice-president, Mrs. Banks S. Baker, was requested to take the chair during presentation of the president's report. Mrs. Don A. Epler moved that the report of the president be accepted with thanks. Seconded by Mrs. A. J. Casselman, this was carried.

The corresponding secretary, Mrs. Irving Baer, read a letter from Mrs. Frank S. Forte, resigning as a Director.

Mrs. Asher Yaguda moved that the reports of the Executive Board be approved as printed. Seconded by Mrs. G. Ruffin Stamps and carried.

The Credentials chairman, Mrs. Edward H. Dyer, reported a total of 202 registered.

Mrs. Ruoff read the proposed revisions to the Constitution and By-Laws of the Woman's Auxiliary to the American Medical Association. These proposed revisions amended Article II—The objects of the Auxiliary and Chapter 4 proposing to change *Hygeia* to *Today's Health*. The proposed amendments were approved by the assembly and our delegates were instructed to vote accordingly to these proposed revisions.

Mrs. Ruoff presented the proposed revision to Chapter VIII, Section 2 of our Constitution and By-Laws increasing the dues to $2 and moved its adoption. Seconded by Mrs. Purcell and carried.

The Parliamentarian, Mrs. Frederick G. Wandall, read Chapter I, Section I on Elections. The following members were then elected to serve on the Nominating Committee: Mrs. Norman Nathanson, Chairman, Mrs. David B. Allman, Mrs. William E. Dodd, Mrs. Philip J. Santora and Mrs. R. J. McDonald.

Mrs. Robert B. Walker, chairman of the Auditing Committee, reported that the books of the treasurer had been found correct and in good order. Mrs. A. J. Casselman moved that the report of the treasurer together with the attestation of the Auditing Committee be accepted. This was seconded by Mrs. Jessurun and carried.

Mrs. Robert B. Walker, chairman of the Nominating Committee, presented the following candidates:

President-elect—Mrs. Thomas H. McGlade
First vice-president—Mrs. Frank S. Forte
Second vice-president—Mrs. Paul E. Rauschenbach
Recording secretary—Mrs. Bertram Sauerbrun
Treasurer—Mrs. Asher Yaguda
Directors—Mrs. Edward H. Dyer
Mrs. William J. Gleeson

Mrs. Asher Yaguda moved that the recording secretary cast the assembly's ballot for

the election of these candidates. This was seconded by Mrs. William Bray and unanimously carried. This was done and the above named candidates were declared elected.

The president appointed Mrs. A. J. Casselman and Mrs. T. P. McConaghy to the Reading Committee.

The recommendation of Mrs. Demaree, chairman of *New Jersey News Note,* that the editor be given her allotted funds outright at the beginning of her year was presented. Mrs. Asher Yaguda moved that this recommendation be accepted. This was carried by standing vote.

Mrs. Jessurun moved that *The Medical History Scrap Book* be renamed *The Medical History Book.* Seconded and carried.

The president reported that since the election of delegates and alternates to the convention in San Francisco had been held, she had been advised that we are entitled to sixteen delegates. She, therefore, made the necessary appointments.

The president introduced our guest speaker, Mrs. David B. Allman, president of the Woman's Auxiliary to the American Medical Association.

Mrs. William Bray, chairman of Rural Health, awarded prizes to Somerset and Burlington Counties. Mrs. Oswald R. Carlander, chairman of Legislation, awarded the prize to Cape May County.

Mrs. Robert B. Walker moved that the members and guests give a rising vote of thanks to the president and her Executive Board. This was done.

TREASURER'S ANNUAL REPORT

Mrs. Asher Yaguda, Treasurer

Cash on hand and in bank April 27, 1949		$1,450.47
RECEIPTS		
Dues	$3,169.50	
Convention funds returned by Mrs. David Allman	86.30	
Sale of handbooks	8.25	
Cash refund from hospitality committee	2.00	
Total receipts		3,266.05
		$4,716.52
DISBURSEMENTS		
National dues (1557 members)	$1,557.00	
President's expenses	97.05	
President's pin	30.00	
Past-President's expenses	34.00	
Bulletin	243.49	
Stationery and printing	203.00	
Handbooks	12.50	
Convention funds	86.30	
Overpayment of dues to Camden County	2.00	
Publication of annual reports	150.00	
Treasurer's expenses	14.00	
Committee expenses	129.94	
Total disbursements		$2,559.28
Cash on hand and in bank May 23, 1950		$2,157.24
Emergency funds		$ 168.68
10% dues 1949-50		316.95
Cash—General fund		1,671.61
Total		$2,157.24

2 Series F. Bonds, face value $100.00 each.

worth noting

0 significant untoward effects in patients who received chloramphenicol under our care."

Smadel, J. E.: J.A.M.A. *142*:315, 1950 (discussion)

0 evidence of renal irritation . . . No impairment of renal function. . . . **No changes in the red-cell or white cell series** of the blood . . . nor did jaundice occur. . . . Drug fever was not observed . . . side effects were slight and infrequent."

Hewitt, W.L., and Williams, B., Jr.: New England J. Med. *242*:119, 1950

0 toxic reactions or signs of intolerance were observed."

Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. *51*:68, 1948

0 symptoms or signs of toxic effects attributable to the drug were observed."

Ley, H. L., Jr.; Smadel, J. E., and Crocker, T.: Proc. Soc. Exper. Biol. & Med. *68*:9, 1948

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THE JOURNAL

OF

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CONTENTS—Pages 409 to 452

EDITORIALS— Page

PRESIDENT'S MESSAGE: MARGINS OF MEDICINE... 409

ARE DOCTORS CITIZENS? 410

THE PHYSICIAN AND THE LAY LABORATORY..... 411

ORIGINAL ARTICLES—

ROLE OF THE GENERAL PRACTITIONER IN 1950 MEDICINE—Aaron H. Horland, M.D., Newark, N. J. 412

TRACHEO-ESOPHAGEAL ANOMALY IN SIBLINGS—Benjamin Copleman, M.D., Benjamin V. Cannata, M.D., and William London, M.D., Perth Amboy, N. J. 415

TYPHOID FEVER TREATED WITH CHLOROMYCETIN—James F. Gleason, M.D., Atlantic City, N. J., and Samuel Goldstein, M.D., Mays Landing, N. J. 416

IMMUNOLOGY IN HEMATOLOGY—Frank W. Konzelmann, M.D., Atlantic City, N. J. 419

ANORECTAL DISEASE AND GASTRO-INTESTINAL DISTURBANCES—J. GERENDASY, M.D., Elizabeth, N. J. 421

CONGENITAL ABSENCE OF THE GALL BLADDER—Leon E. De Yoe, M.D., and John J. Castronuovo, M.D., Paterson, N. J. 422

IODO-ACETATE INDEX IN CANCER — Samuel M. Gilbert, M.D., Samuel A. Goldberg, M.D., J. E. Tausz, D.Sc., and Marta Tausz, D.Sc., Newark, N. J. 424

ORIGINAL ARTICLES— Page

MULTIPLE MYELOMA—Curt Bluefeld, Jr., M.D., Nutley, N. J., Robert H. Ringewald, M.D., and Sau Fong Cheung M.D., Englewood, N. J. 426

BANTHINE IN THE CONTROL OF DUODENAL ULCER—A. I. Friedman, M.D., Hackensack, N. J.. 428

CLOSED BRAIN INJURIES—Felix Frisch, M.D., Trenton, N. J. 431

THE CLINICAL USE OF BALLISTOCARDIOGRAPHY—Max Greenberg, M.D., Linden, N. J. 434

A SIMPLIFIED CORD TIE—Alvin H. Krakower, M.D., and Tamara Nabolotny, M.D., Paterson, N. J. 440

WE MUST FIGHT ON—Mrs. David B. Allman, Atlantic City, N. J. 442

STATE ACTIVITIES—

Parathion Poisoning 444

Tropical Disease Abstracts 444

Symposium on Mental Deficiency 445

Memo to Bellevue Alumni 446

OBITUARIES 447

COUNTY SOCIETY REPORT 447

PUBLIC HEALTH NEWS 448

WOMAN'S AUXILIARY 449

BOOK REVIEWS 449

TUBERCULOSIS ABSTRACTS 451

Roster of Officers and Committee Chairmen, Advertising Page 3A

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Founded July 23, 1766

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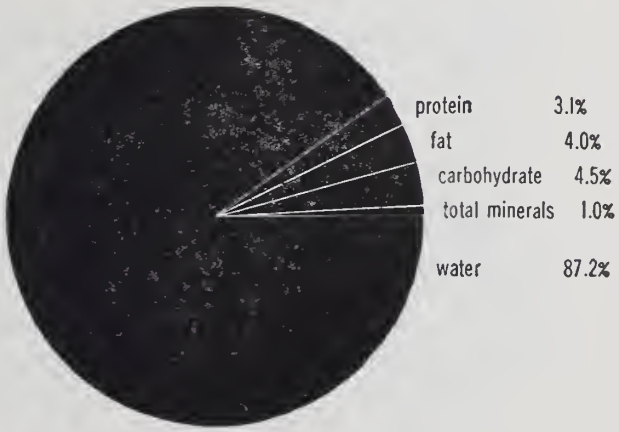

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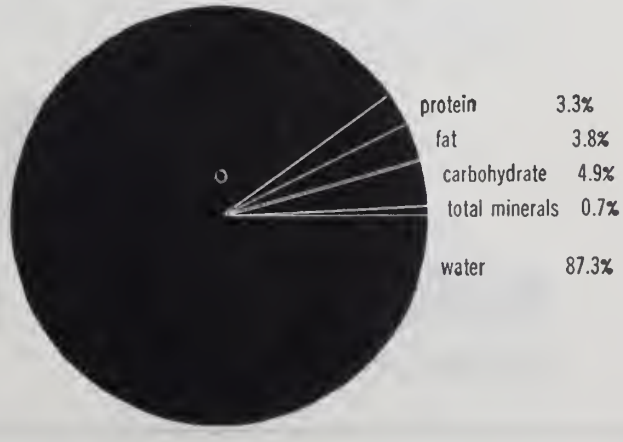

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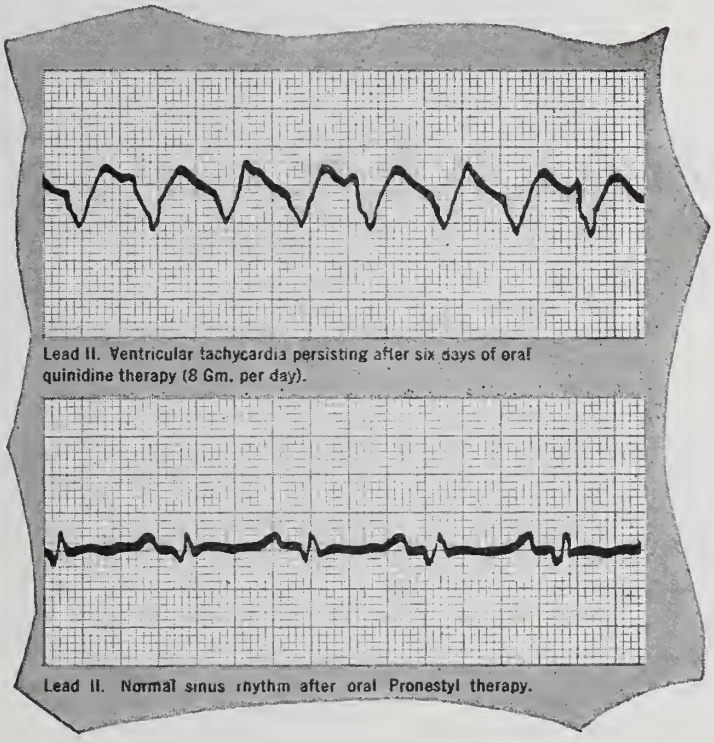

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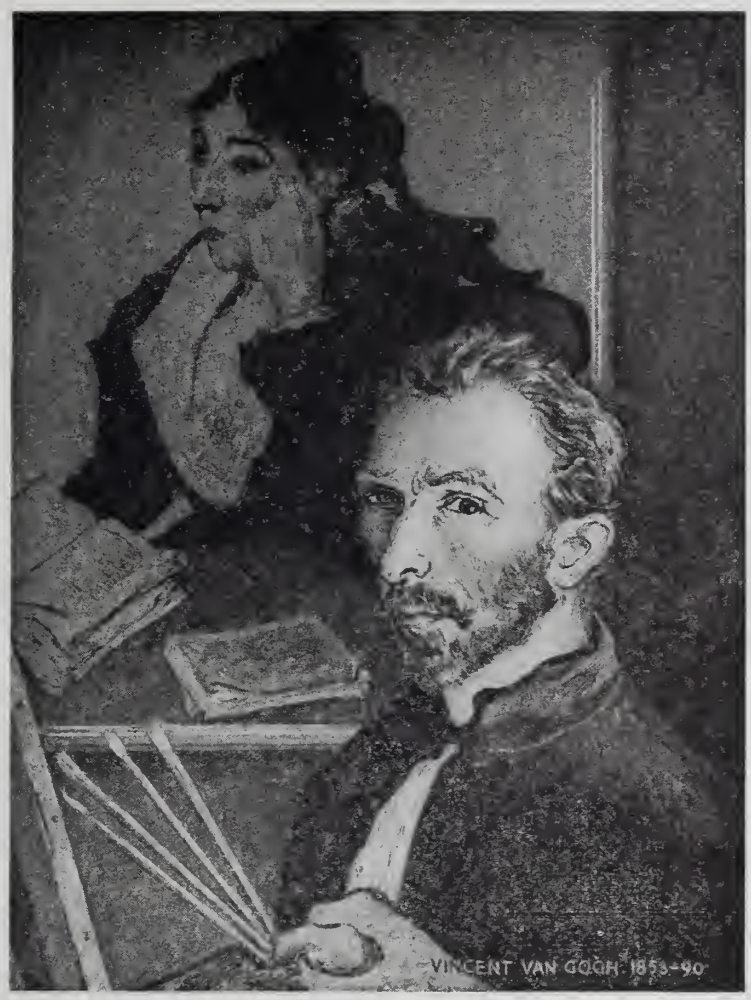

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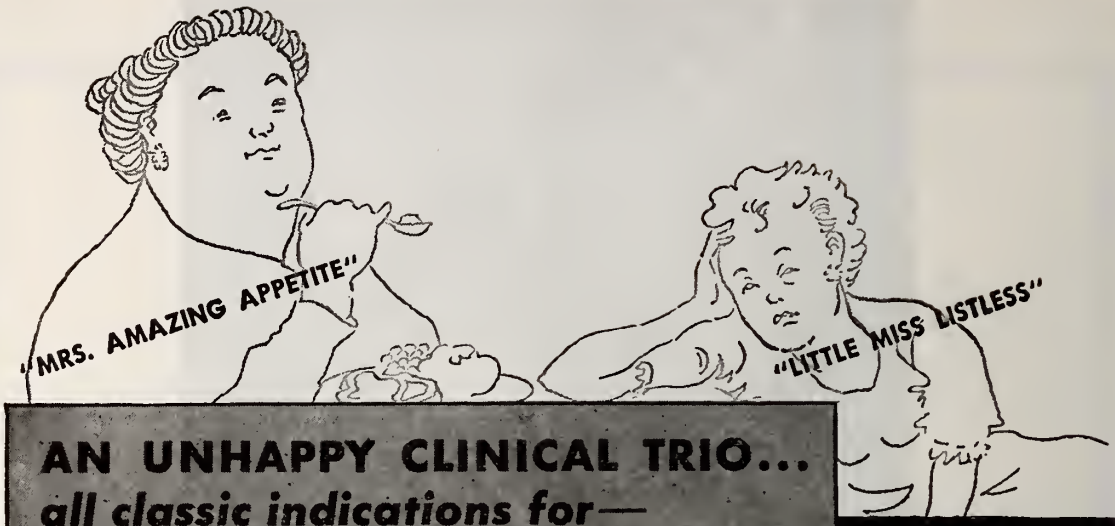

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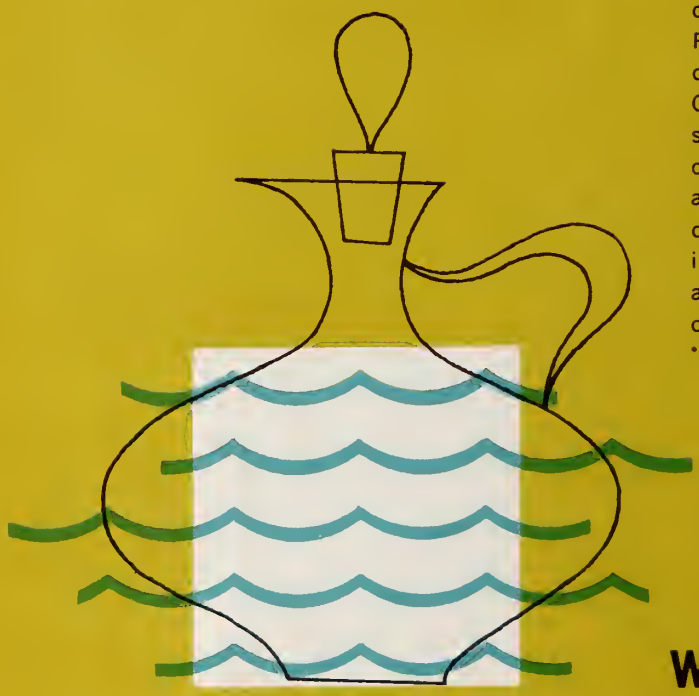

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1. Lewis, J. M., Cohlan, S. Q., and Messina, A.: Pediatrics 5:425, 1950.
2. Lewis, J. M., and Cohlan, S. Q.: Med. Clinics North Amer., March, 1950.

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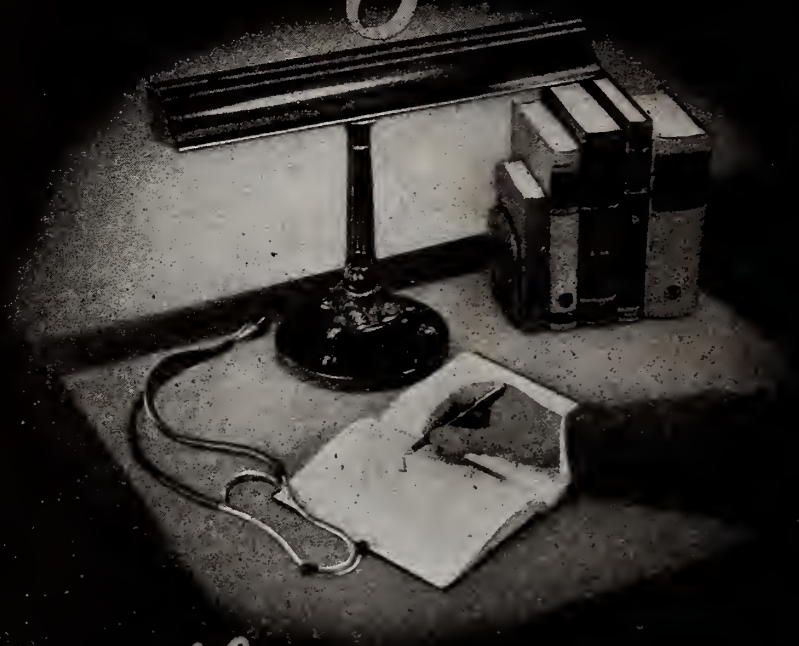

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[1]Cooke, R. A.: *Allergy in Theory and Practice.* Philadelphia: W. B. Saunders Company, 1947, p. 186

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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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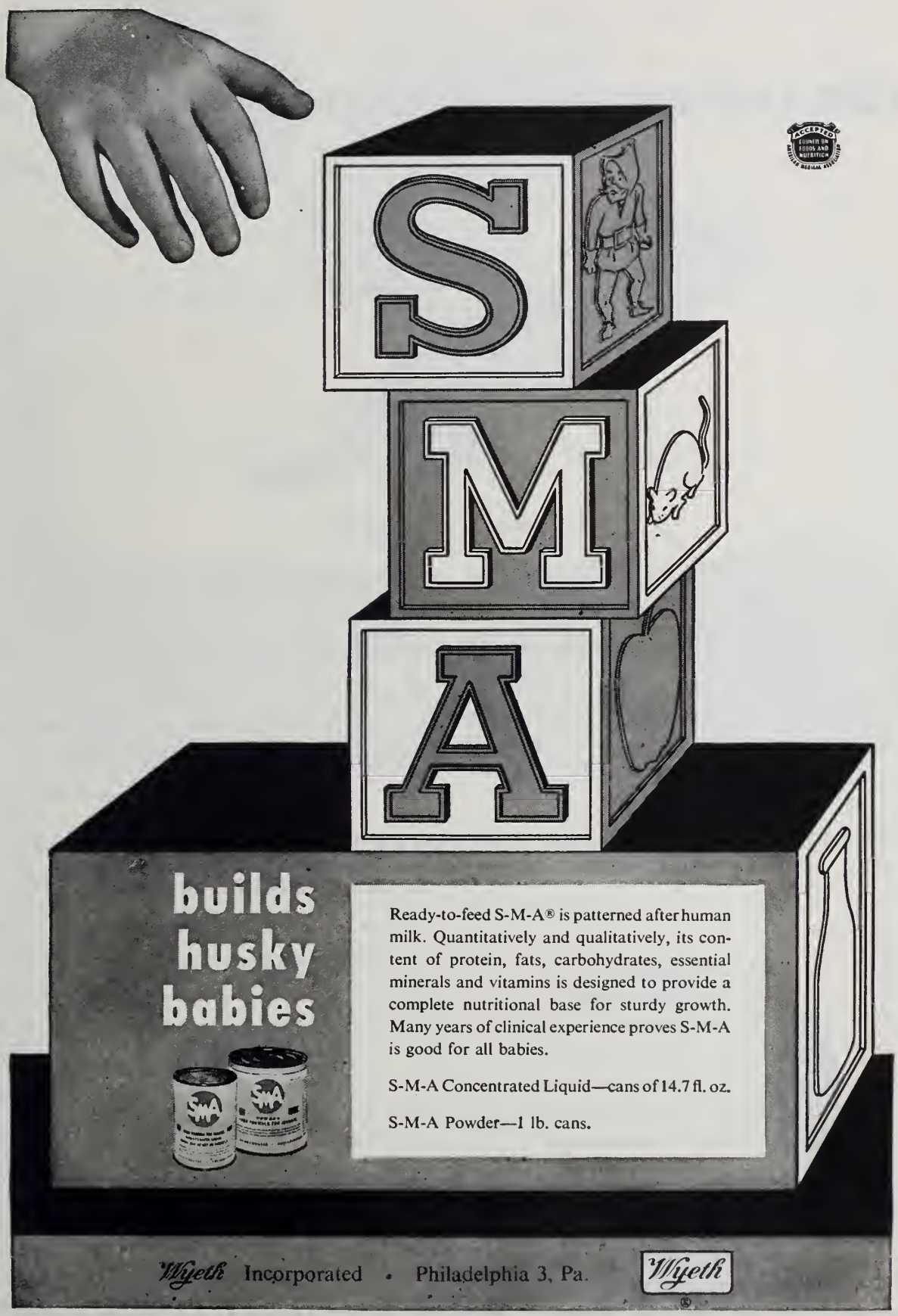
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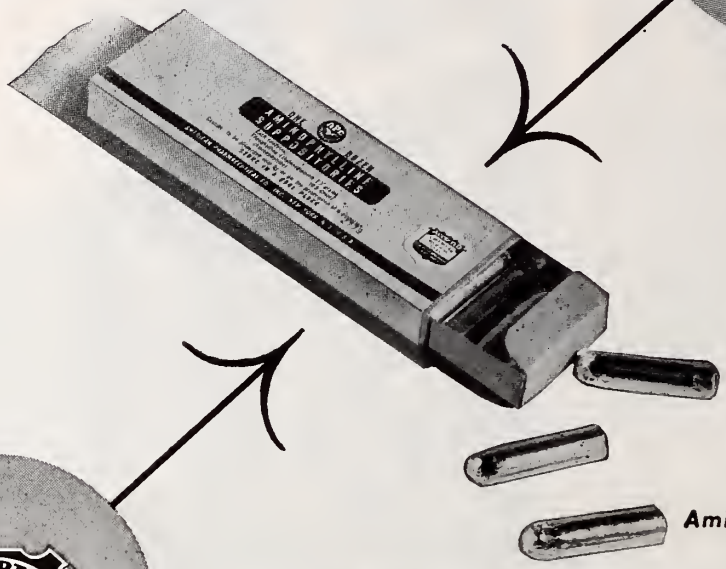

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PRESIDENT'S MESSAGE: MARGINS OF MEDICINE

Of all professions, medicine is, perhaps, the one most infiltrated with eager lay practitioners, nibbling at its margin. It is astonishing how many nonmedical persons are available—always in the polite guise of "assistants"—to take over some of the doctor's function. It all started innocently enough. There was, first, the nurse,—a helpful young lady who made beds, carried bedpans, gave hypodermic injections when we told her to, massaged the patient's back, took the temperature, and performed countless other indispensable chores. But nurses now want to be practitioners in their own right. In many clinics they take blood-pressures, as well as pulses; they give intravenous injections as well as hypodermics. In hospitals they scorn direct care of the patient, as a menial task fit only for orderlies or ward-maids, and beneath the dignity of a college graduate with a degree in nursing education. They now do public health work and operate crippled children's clinics, and administer therapeutic equipment once thought to be the exclusive province of the doctor of medicine. But the nurses are our friends and helpmates and perhaps we should accept this with good grace.

Joining the nurse are a dozen other semiprofessional persons. Occupational therapists, for instance, once content to teach patients how to perform certain vocationally useful acts, are now asking that the doctor simply furnish the diagnosis, while they, armored in their shining new "professional" status, write out the specific occupational prescription. Laymen operate laboratories — both pathologic and roentgenologic, and boast of many physician-supporters. The optometrist goes through the motions of looking at the fundus, and the chiropo-

dist is pained if he is not called "doctor". Psychologists and social workers are enthusiastically ready to take over from the psychiatrist. Record library work, once essentially a clerical function, is now a new "profession", with the record librarian teaching us what diagnostic terms we may, with their permission, use on our clinical records. There are—believe it or not— bibliotherapists who prescribe appropriate reading for the patient, speech pathologists who train stutterers and laryngectomized patients, and physical therapists by the score who look askance at the M.D. who tries to operate the equipment or even to suggest what physical modality to use. If a patient needs a special diet, there is a bevy of dietitians (or, perhaps, "nutritionists") who will not only tell him how to cook the liver, but who will, once you say "nephritis", work out the entire dietetic regime with much explanation about the function of the renal glomeruli.

When a child is born, there is now a dietitian to work out his feeding schedule and a psychologist to formulate his play schedule. At school a nurse measures his refraction, and an optometrist may prescribe his glasses. A technician takes chest x-ray and his blood sample. A social worker finds him a summer camp where a "recreationalist" (if there isn't such a profession, there soon will be) prescribes his activities. And so it goes, until soon the doctor of medicine will be but the feeding station for the lay practitioner.

This is, perhaps, our own fault. We have been too busy to do for ourselves, many of these tasks. Our subject is so vast that large areas must remain unknown to us, and we are easily persuaded that physical medicine, or speech training, or foot care, represent unknown territories into which we venture only at our peril. And we have been generous in accepting these assistants, seeing them only as subprofessional aides, sparing us some routine chores. But their status has grown from subprofessional to semiprofessional to professional; and by now, the prefix "doctor" may indicate a "hair care specialist" or a corn-parer or indeed anything in between.

Let us face the fact that we can never delegate professional responsibility to anyone except another physician. It may save us a little trouble to call on the dietitian or the chiropodist, the physical therapy technician or the psychologist. But let a patient be harmed, and a malpractice suit loom over the horizon, and the lay practitioner quickly scurries to cover. "After all", he says, "I'm not a physician. I work under the 'supervision' of the doctor. Sue him, not me." Morally and legally, the responsibility is irrevocably ours. We fool only ourselves when we turn a patient over to the lay practitioner. The doctor is still captain of the therapeutic team. Let him play the role of the captain: supervise, control and lead.

Aldrich C. Crowe, M.D.

ARE DOCTORS CITIZENS?

Some people in this country are not altogether certain of the answer to the question: are doctors citizens? From several strange sources has come the astonishing demand that payment for doctors' services be made by government paymasters. Apparently some people think the doctor is different from other citizens, with a different sort of civic obligation and a different sort of individual rights.

No other professional man in America — no businessman, no butcher, no plumber, no baker, no clergyman, no

grocer, so far as we know — has to date been nominated to share with the doctor the dubious distinction of having his income paid by government and his product or service made "free" to all comers. It is conceivable such suggestions may come later. Certainly in the logic of expanding paternalism, a case could be argued for making the work of all these essential people a function of government. Indeed, it may be that some day such a case will be urged. We have an idea that when it is, it will split wide open on the plumber. There is a hard core of common sense in the American people and a blunt insistence on the individual freedom of every man.

There are a good many things American citizens won't stand still for—and don't expect other citizens to stand still for either. Which brings us back to the question, "Are doctors citizens?".

We'll know more about the answer after November. The coming elections will give the whole country a good yardstick with which to measure the citizenship of the medical profession. Is it a citizenship that influences government, a citizenship that is informed about candidates, a citizenship that means registration and voting for the candidate chosen? Or is it negative and passive when faced with the vital issues of an urgent time? Is it too busy to be concerned with the public business of democratic government?

The answer is up to every doctor. And the testing time will be the coming elections.

This is the time for doctors to demonstrate in action what their citizenship means in America. Conceivably, it may be the last time.

THE PHYSICIAN AND THE LAY LABORATORY

An enormous increase in the scope of laboratory procedures is one of the features of medical science in the middle of the twentieth century. Electrocardiograms, electro-encephalograms, roentgen diagnosis, and an endless array of laboratory tests have given us windows through which we can see much human physiology in action. The doctor's attitude towards these procedures fluctuates from slavish dependence to total rejection. At times the physician stands mute before a chart full of tests and yearns for the good old days when a coated tongue, a rapid pulse, and clinical hunch were the desiderata of bedside practice. At other times he hesitates to diagnosis a cold without first getting a liver function test. Between these extreme attitudes, the profession is hammering out a useful and acceptable status for laboratory procedures. The conventional attitude now is that the tests are helpful if they are filtered through clinical judgment.

This is a sound thesis, but it raises the question: whose clinical judgment? The family doctor does not, even in the course of a busy practice, have much occasion to interpret blood amylase concentration, a complicated soft-tissue x-ray, a peculiar electro-encephalographic tracing, or the sulfur content in the residuum of a gastric analysis. The only practitioner who can effectively interpret such findings is the clinical pathologist or, in the case of abstruse x-rays, the physician specializing in roentgenology. The technician can perform the test but cannot be asked even to interpret the single finding, let alone integrate it into the total clinical picture. And a laboratory operated by a layman is necessarily in the hands of technicians. Just as the thoughtful physician does not use a midwife as an obstetrical consultant, so he avoids the lay laboratory for roentgenology and for important clinical laboratory studies.

ORIGINAL ARTICLES

ROLE OF THE GENERAL PRACTITIONER IN 1950 MEDICINE*

Aaron H. Horland, M.D., Newark, N. J.

General practice represents one of the most important branches of medicine. Most people look to the family doctor for the solution of their medical problems. He is usually the first to see patients with borderline diseases. He is called upon to diagnose psychosomatic ailments, heart disease, cancer, tuberculosis, diabetes mellitus, and many other conditions, in their early stages. To do this efficiently and adequately, the general practitioner must be as well trained and skilled as any of his brother specialists. The general practitioner of 1950 must meet the same requirements of continued graduate study as any of the specialist groups.

The training of general practitioners, so that they will be on a professional level with the rest of the profession, presents two problems. The first is one of training the future general practitioner; the second is one of raising the level of present practice. Not until very recently has any attention been directed toward the development of general practitioners in our medical schools. Specialists had direct contact with medical students, and rarely in their training was any thought given to their future as general practitioners. It was natural, then, for the students to set their sights towards specialism. Now that the problem has been recognized, many medical schools throughout the United States have established preceptorships, so that the medical student, in his fourth year, has a chance to spend some time with the general practitioner, and learn what general practice means. In the past year, many hospitals, including several with university affiliations, have established general practice residencies, which compare favorably with those offered in the specialties.

The second problem is to raise the standard of general medical practice. This raises two additional questions. One is that of better hospital integration; the second is adequate graduate training for general practitioners in rural areas.

In many hospitals, the general practitioner who has an active staff position is made to feel that unless he points his postgraduate training toward board certification, he will not advance, and may even lose the staff position he holds. He is not allowed to perform such simple procedures as an episiotomy, delivery by low forceps, or tonsillectomies; he may not be permitted to assist at operations, to give after-care to his surgical patients, or to accomplish other medical and surgical procedures for which he is well qualified. Many general practitioners have to be satisfied with courtesy staff appointments which prevent them from participating in ward services, thus limiting their medical progress.

In several counties in this state, some general practitioners cannot treat any of their cases in any hospitals in their community. In all the hospitals, his privileges are markedly limited, and in no hospital are his privileges defined in accordance with his skill, training and experience. Some hospitals have gone so far as to try to limit regular, active staff appointments to board diplomates, or to those eligible for certification. These injustices can be remedied by the establishment of a general practice section in our general hospitals.

In smaller communities, hospital connections may not be important; but graduate education is. And in those areas away from metropolitan centers, this type of training must be brought to the general practitioner.

The introduction of a general practice section into hospitals is based upon the idea that the general practitioner should be recognized

* Read before the Section on General Practice of The Medical Society of New Jersey at its 184th Annual Meeting, Atlantic City, May 24, 1950.

as such in the staff structure of the hospital. Integration is accomplished by organizing an administrative general practice section. This section is composed of general practitioners with a chief, associates and assistants. Through this section, the general practitioner has a voice in shaping the medical and organizational policies of the hospital.

A qualifying committee composed of specialists and general practitioners, coordinates the work of the general practitioners on the specialist services, and defines the privileges of the former. Exactly how a general practice section would operate, depends upon the size of the hospital, and the number of general practitioners on its staff. The details of incorporating such a plan into a hospital may be found in a manual on *The Establishment and Operation of the Department of General Practice.*†

A general practice section not only will promote the training and skill of the family doctor, but will create an incentive for him to do his best work. And most important of all, it will assure the general practitioner of a proper staff position.

In 1945, the American Medical Association, recognizing the need for more general practitioners, and realizing that the problem required investigation, established a general practice section. After a two year study, it was found that the problems were so diversified, and had so many ramifications, that it was decided they could best be handled by an independent association of general practitioners. In 1947, the American Academy of General Practice was accordingly organized. Within three years it has grown to a membership of over 15,000.

Has solo medicine a place in 1950 medical practice, or has the general practitioner become an anachronism? Is the family doctor a holdover from the horse and buggy era, or does he have a necessary place in this age of specialism? In the last quarter of our century, the status and prestige of the family doctor gradually fell to the bottom rung of the medical ladder. As this trend continued, the number of physicians entering upon a career of general practice grew less. In a recent survey (conducted by the New Jersey Academy of General Practice) the 5000 physicians of New Jersey were sent questionnaires. Of all the physicians who received the questionnaires, 1160 responded. Results of the survey follow:

Those who were in general practice numbered 707, and the specialists numbered 450. Those who limited their practice "to some extent" numbered 279, and those who did not limit their practice at all, numbered 508. Of the 707 general practitioners, 500 have staff appointments. Of the entire 707 general practitioners, 177 were members of the American Academy of General Practice, and 520 were non-members. To appreciate what this means, let me analyze this survey.

While only 20 per cent answered this survey, we can draw some general conclusions. First, let us calculate the proportion of specialists to general practitioners in New Jersey: 707 to 450; that means less than two general practitioners for every specialist. Dr. Ernest Irons, past-president of the American Medical Association has said that the minimum relationship should be four general practitioners to one specialist. Considering only full-time specialists, we find the New Jersey ratio to be two to one. If we add the 279 doctors who "limit their practice in some form" to the ranks of the specialists the ratio falls to one to one. To put it in round numbers, best opinion is that 80 per cent of all physicians in private practice should be general practitioners. In New Jersey this figure is no higher than 50 per cent. In fact, when you consider that specialists were less likely to reply to our questionnaire than general practitioners, the actual ratio of general practitioners is probably even less than this 50 per cent figure. Something has to be done to change this alarming trend, and it is my purpose in this presentation to suggest concretely what can be done.

Organized medicine must realize that the development of our science is giving the general practitioner an ever more important role. As specialties multiply and become more complex, and the technics more difficult, there is increasing need for the highly educated doctor, with a wide outlook, who knows his patient

† Published by the American Academy of General Practice, Kansas City.

from observation over years, knows his environment, knows his family background, and can view his case *as a whole*. He will know when to call in the aid of a specialist, and will be able to appraise his advice. There is a danger to the patient who chooses his own specialist, and often wanders from one to another with no family doctor to help him.

The growth of specialization and the certification of specialists, have tended to eliminate the general practitioner from general hospitals. Too few hospitals provide for integration of general practitioners with the staff of the hospital, or with its work. The staffs of hospitals are organized to provide departments for individual specialists, who devote themselves in their teaching to the training of residents and assistant residents. They provide little of importance for the advancement of the general practitioner. The tendency should be rather to provide beds for utilization by general practitioners in the care of their patients.

The Medical Society of New Jersey has adopted a policy of recommending general practice sections in all nonspecialized hospitals. It should now take the next step and assist hospitals of New Jersey to establish such sections. The Council on Hospitals of the American Medical Association and the American College of Surgeons have both recommended establishment of general practice sections. The American Academy of General Practice has spent three years developing a plan flexible enough to be incorporated into the organization of any hospital desiring to establish a general practice section.

Surveys indicate that there is a shortage of physicians. Due to the disproportion between specialists and general practitioners, there is a surplus of specialists and a shortage of general practitioners. It is, therefore, the responsibility of organized medicine to see to it that the well trained general practitioner not only becomes more numerous, but also becomes an important part of the active hospital staff. In this way high-grade medical care can be supplied to the greatest number at low cost, without impairing one of the profession's most precious assets: the family doctor-patient relationship.

129 Chancellor Avenue

POLITICAL MEDICINE

This new propaganda to cure our ills,
Proposes a plan with political pills—
Compounded, dispensed to serve a great need,
Misleading in fact, it's deceptive indeed.

With death of your treasured freedom to choose,
Your private physician you'll certainly lose.
Who'll guard your deep secrets—secrets unknown?
And more if you sin when it's not all your own?

Your taxes will soar and you'll just stand in line
For a three-minute guess—"What's wrong with my spine?"
Embarrassing moment, to hear you complain
If your illness reveals a secret old pain.

This political dose will hasten your death,
You'd better say No—before your last breath!

—H. Ameroy Hartwell, M.D.,
Weehawken, N. J.

DR. MAXWELL JOINS KESSLER INSTITUTE

The Trustees of the Kessler Institute for Rehabilitation, West Orange, N. J., announce the appointment of Carl Arthur Maxwell, M.D., of 39 South Street, Morristown, N. J., as Associate Medical Director of the institute.

Dr. Maxwell is a diplomate of the American Board of Orthopedic Surgery. From 1948 to 1950 he was chief orthopedist at the Veterans Hospital in Cleveland, Ohio. From 1946 to 1948 he was resident orthopedist at New Orleans Veterans Administration Hospital, and held a fellowship at Children's Orthopedic, Tulane University. During the war, he was chief of orthopedics at the station hospital, Camp Kilmer.

COURSE IN ELECTRO-CARDIOGRAPHY

An intensive 5½-day course in electro-cardiography is announced for the week of September 25, 1950. The course will be given at Mt. Sinai Hospital, New York. For details, write to: Registrar for Medical Instruction, Mt. Sinai Hospital, 2 East 100 Street, New York 29, New York.

TRACHEO-ESOPHAGEAL ANOMALY IN SIBLINGS *

Benjamin Copleman, M.D., Benjamin V. Cannata, M. D., and
William London, M.D., Perth Amboy, N. J.

Congenital anomalies of the trachea and esophagus are rare. Their occurrence in siblings is almost unique. A search of the literature, in fact, reveals only one such case ever reported —an instance of congenital esophageal atresia in brothers cited by Grieve and McDermott† in 1939.

They reported a male infant born in January 1937 with the upper end of the esophagus blind. The lower end communicated with the trachea half an inch above the bifurcation. In September 1938 another baby was born to the same parents, with an identical anomaly. The second infant also had an imperforate anus. The parents were third cousins, and the mother reported that she had had a brother who died at the age of ten days of an undetermined "bowel condition".

We are here reporting a case which is, therefore, only the second instance of tracheo-esophageal anomaly in siblings in the literature.

A white male was born in September 1946. He showed a characteristic difficulty in feeding. Chest roentgenograms indicated atelectasis of the right upper lobe. The stomach and intestines contained gas. On attempting to pass a tube into the stomach, an obstruction was encountered in the esophagus, just above the level of the tracheal bifurcation. At operation, the upper esophageal segment was seen to be a blind tube attached by a short fibrous cord to the trachea above the bifurcation. The lower end started from a point at the bifurcation and pursued a normal course through the diaphragm into the stomach. The patient did not survive the attempt at surgical correction. Autopsy was not obtained.

Another male infant was born to the same parents in November 1947. The infant had labored respiration. A chest roentgenogram showed early atelectasis in the right upper lobe and the absence of gas in the stomach and intestines. A small amount of lipiodol was injected into an esophageal tube and a bronchogram taken. The patient died within a week of peritonitis following the establishment of a gastrostomy. At autopsy, a fistula was found between the upper end of the esophagus and the trachea at about the level of the tracheal bifurcation. The lower end of the esophagus extended upwards from the stomach for about an inch and terminated in a fibrous cord.

This same mother gave birth to an apparently normal female in January 1949.

SUMMARY

The second instance of tracheo-esophageal anomaly in siblings is recorded. In this case and in the only other report we could find, the infants involved were all males.

280 Hobart Street

ARTHRITIS RESEARCH FELLOWSHIPS

The Arthritis and Rheumatism Foundation is offering fellowships for research in sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000, and run for a period of one year. Fellowships will normally begin in July 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate, rather than a project, an institution, or a hospital. If interested, write to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, before January 1, 1951.

* From the Perth Amboy (N. J.) General Hospital.

† Grieve, I. G., and McDermott, J. G.: Canada Medical Association Journal, 41:185 (1939).

TYPHOID FEVER TREATED WITH CHLOROMYCETIN

A CASE REPORT *

James F. Gleason, M.D., Atlantic City, N. J., and
Samuel Goldstein, M.D., Mays Landing, N. J.

Although typhoid fever has been recognized as a disease entity since 1820, it has been only since 1948 that we have had an apparently specific therapeutic weapon.[1] This paper will consider certain practical problems in the laboratory diagnosis of typhoid fever which have arisen during the use of Chloromycetin and other antibiotics.

It is fortunate from a public health point of view that typhoid is now such a rare disease. The records of the Atlantic City Hospital, which services a wide area of southern New Jersey, include eight cases during the past four years. The case to be reported is one of these and is the first treated in this hospital with Chloromycetin.

A 27 year old housewife, was admitted to Atlantic City Hospital on October 15, 1949, complaining of fever of ten days' duration.

Her mother had had typhoid fever 30 years ago. Her mother-in-law had had "walking typhoid" many years before, with subsequent gallbladder disease. The family history is otherwise non-contributory.

The patient is a native of South Carolina. During childhood, she had had malaria, described as a "week of fever". There had been no definite relapses, but she had had "grippe" at least three times. She recalls measles and mumps but denies scarlet fever. She had the usual childhood inoculations but neither she nor her mother could be sure whether typhoid vaccine was included. She had had an uneventful Caesarian section five years ago because of a "small pelvis".

She had been in good health until ten days before admission to the hospital, at which time, she abruptly developed shaking chill, followed by fever, profuse perspiration, and severe occipital headache. This initial episode lasted 1½ hours. During the next ten days, this sequence was repeated many times, with temperature in excess of 104 degrees, accompanied by progressive weakness, anorexia, and lethargy. There were no gastro-intestinal symptoms. Abdominal pain was absent. She had slight urinary frequency and burning. Two "fainting spells" occurred during the 48 hours preceding admission.

One blood smear for malaria on October 12, 1949, had been negative. Her white blood count at that time was 6,000 of which 62 per cent were polynuclears. She had had a therapeutic trial of quinine and three intramuscular injections of penicillin, without apparent benefit. During the two days before admission, she had been given 15 capsules of Aureomycin (250 milligrams each) at three hour intervals.

There was no history of ingestion of unpasteurized milk, of tick, rat or insect bite, nor of exposure to parrots or other domestic birds. During her five weeks' visit in New Jersey, however, she had been living in a rural area regularly drinking well water. Sewage disposal from the house was by septic tank. Seven days before the onset of her illness, she had eaten a dozen raw clams at a nearby restaurant. It is impossible to estimate to what extent these factors contributed to the present illness.

Physical examination was relatively non-informatory. Blood pressure was 110/70, pulse 120, and temperature 101.4. She was pale, dehydrated, and acutely ill. A rash was not observed. There were no palpable lymph nodes. Liver and spleen were not felt. Examination of the heart and lungs revealed no unusual findings. The remainder of the physical examination was within normal limits.

X-ray examination of the chest on admission showed nothing abnormal. Hemoglobin was 11.5 Grams per 100 cubic centimeters (82 per cent); erythrocytes were 3,960,000. Total leucocytes were 5250 of which 73 per cent were polymorphonuclears. Of these, 66 per cent were non-filamented forms, 24 per cent lymphocytes and 3 per cent monocytes. White blood cell counts were almost identical on the following two days, but on October 19, 1949, there were only 52 per cent polymorphonuclears, with 32 per cent non-filamented forms. Sedimentation rate (Cutler method) was 16 millimeters in 30 minutes. Agglutinations for paratyphoid "A" and "B", Brucella abortus, Proteus OX19, and heterophile antibody were consistently negative on three examinations. Agglutinations for Typhoid "O" and "H" are recorded in the table. Repeated thick and thin smears for malaria, taken always at the height of a chill were negative. Urinalysis showed 4-plus acetone, which cleared as hydration was restored.

Cultures of the well water by the Atlantic City Hospital laboratory and by the New Jersey Department of Health were negative for enteric pathogens. Stool cultures positive for typhoid bacilli were delayed, due to difficulties in culturing and in obtaining satisfactory specimens. Enema specimens taken 4 and 28 hours after the institution of Chloromycetin therapy were reported as follows: "No enteric pathogens found; heavy growth of Pseudomonas aeruginosa; light growth of colon bacilli."

* Presented at the Ventnor Clinic Staff Meeting, Atlantic City, New Jersey, March 7, 1950.

Four blood cultures (each taken during a chill) were negative. However, the first blood culture, taken on the day of admission (October 15) and twice subcultured, finally yielded an organism, identified morphologically and serologically as Salmonella typhosus. This was identified after the patient left the hospital and eleven days after admission. The identification of the organism was later verified by the University of Pennsylvania laboratories[2] and by the Communicable Disease Center in Atlanta, Georgia.

The patient's course in the hospital is indicated in the figure.[3] Her temperature reached 105 on the second and 106 on the third hospital day. It was at this point (60 hours after admission, and 13 days after the onset of fever) that Chloromycetin therapy was begun. She was given an initial dose of 4 Grams (16 capsules), followed by an equal amount in four hours, and then one capsule (250 milligrams) every three hours thereafter. Forty-eight hours later, intramuscular penicillin, 300,000 units (crystalline) every three hours was started, and later reduced to every six hours. Parenteral fluids were given as indicated.

Temperature returned to normal 3½ days after Chloromycetin was first given and 1½ days after start of pencillin therapy. She was discharged nine days after specific treatment was instituted but was continued on bed rest and Chloromycetin for two more weeks. When last seen (November 18) she had gained twelve pounds and was completely well except for tremulousness of the hands.

Stool and urine cultures on November 15, 1949, were negative for enteric pathogens. Agglutinations for Typhoid "O" and "H" antigens on January 28, 1950, are reported in the table. Stool cultures on the same date failed to yield typhoid organisms. At this writing, three months following her acute illness, the patient has begun to lose her hair.

		October 17, 1949			
Dilution	1:20	1:40	1:80	1:160	1:320
Typhoid "O"	plus 4	plus 3	plus 2	plus 1	negative
Typhoid "H"	plus 3	plus 2	plus 1	negative	negative
		October 19, 1949			
Typhoid "O"	plus 4	plus 3	plus 2	plus 1	plus-minus
Typhoid "H"	plus 4	plus 4	plus 3	plus 1	plus-minus
		October 24, 1949			
Typhoid "O"	plus 4	plus 3	plus 2	plus 1	plus-minus
Typhoid "H"	plus 4	plus 4	plus 3	plus 1	plus-minus
		January 28, 1950			
Typhoid "O"	0	0	0	0	0
Typhoid "H"	0	0	0	0	0

NOTE: The January report is from the South Carolina Department of Public Health; all other agglutinations were by the Atlantic City Hospital laboratories.

The diagnosis of typhoid fever used to be simple:—the disease was common, the clinician always had a high index of suspicion, the patients had been ill long enough so that stool or urine cultures were positive in 80 per cent by the end of the third week,[4] and, above all, cultural and immunologic responses had not been altered by previous antibiotic therapy. It is, therefore, striking in this enlightened age,

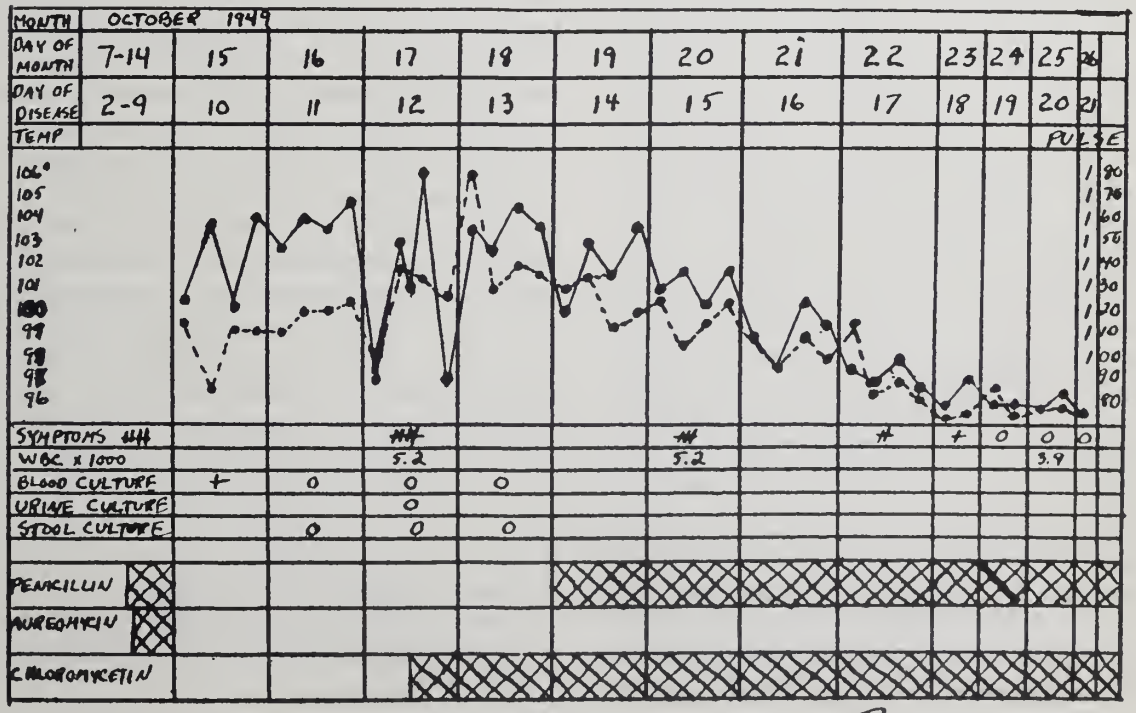

Figure 1

Pulse ----
Temp ——

despite the enthusiastic cooperation of an excellent bacteriologic laboratory, that the diagnosis of typhoid fever, although suspected early, was not confirmed until nine days after specific therapy had been instituted, five days after specific response to Chloromycetin, and six hours after her discharge from the hospital. In interpreting this, many factors must be considered. First, there is the very practical difficulty encountered in almost every general hospital in accomplishing early stool cultures. This is particularly true when a patient is admitted on a weekend. The situation is aggravated by existing personnel shortages. It behooves the individual clinician and the members of the house staff interested in problems of this sort, to exert every effort (not excluding taking the specimen to the laboratory and plating the culture himself) if he wants to make an early specific diagnosis of enteric infection. If there are no spontaneous movements, enema returns or washings after a normal saline enema, should be cultured.

Second, there is a real question whether the typhoid bacillus would have successfully been cultured from this patient's stools, even if specimens had been obtained early. She had had 3.75 Grams of Aureomycin before admission. The reports of the effects of this drug in Salmonella infections have been conflicting. Dowling and his co-workers[5] noted neither clinical nor bacteriologic response in their typhoid patients. Schoenbach *et al.*[6] obtained negative blood and stool cultures within 48 to 72 hours in three cases of typhoid, but observed variable clinical results. Ross and colleagues[7] noted little effect of Aureomycin in two cases, while Collins and associates[8] reported conversion of blood and stool cultures to negative in five cases. It is conceivable then, that admission stool cultures may have been negative as the result of the Aureomycin therapy. This may also explain why the positive blood culture required twelve days, and two subcultures. From an academic point of view, we must agree with those who criticize the wide-spread use of the newer antibiotics for "fever", without a specific etiologic diagnosis. Our position here is, of course, precarious, since we were forced to use Chloromycetin in this patient at a time when she was so ill that we no longer felt justified in waiting for a bacteriologic diagnosis.

Third, we must wonder about the effect of Aureomycin and Chloromycetin on the Widal reaction. In this patient, the history of immunization against typhoid in childhood is equivocal. At no time during her disease did she show a significant rise over her initial titer. Electrophoretic protein partition studies in typhoid patients treated with Chloromycetin would seem to be in order. This might throw some light on the mechanism of antibody response to bacterial infection, which is, as yet, poorly understood.[9] It is interesting to speculate whether some effect of Aureomycin might be responsible for the absence of classical bradycardia, and for the initial predominance of non-filamented polymorphonuclear leucocytes. These findings, plus the failure of rise of agglutination titer combine to suggest an altered reaction of the defense mechanism in this case. A study of the agglutination reaction in a large series of typhoid patients treated with Chloromycetin is indicated. It is apparent from this patient's clinical course that she showed no clinical response to Aureomycin in the dosage given. Her response to Chloromycetin was dramatic and in keeping with that previously reported. In the light of the ultimately positive blood culture for Salmonella typhosus, the use of penicillin in large dosage might be considered wasteful. At the time it was given, however, a positive bacteriologic diagnosis could not be made and we were considering a streptococcus viridans subacute bacterial endocarditis as a diagnostic possibility.

SUMMARY

A case of typhoid fever with unusual clinical and immunologic features has been described. A striking therapeutic response to Chloromycetin was observed.

The footnotes appear in the authors' reprints.

IMMUNOLOGY IN HEMATOLOGY*

Frank W. Konzelmann, M.D., Atlantic City, N. J.

THE Rh FACTOR

That immunologic phenomena might play a role in the cause of blood dyscrasias (especially in the newborn or in the pregnant woman) was suspected but never demonstrated until the paper of Levine and Stetson appeared in 1939. In the following year, Wiener and Landsteiner announced the discovery of the Rh factor. Much has been learned in the years which have followed. It is now apparent that the antigenic substance Rh is resident in the erythrocyte. It is absent from body fluids and probably from all other body cells. Rh antibodies are formed in Rh negative persons who have the genetic capacity to respond to the antigenic stimulus when Rh positive cells are introduced into the body by any route. Introduction by transfusion was common in the past but is now avoidable. Transplacental iso-immunization, its mechanism and methods of demonstration occupy a prominent place in the field of immunology. The manner in which the erythrocytes of an Rh positive fetus pass the placental barrier is still far from settled. It has been reported[1] that immunization in first pregnancies does not begin until after midpregnancy, when the placenta is large and exposes a tremendous surface to the maternal circulation. Structural and physiologic changes occur which might permit passage of a small number of fetal cells through an intact placenta into the maternal vessels. Most investigators believe it is unlikely that placental defects or disease are necessary and certainly their existence has not been satisfactorily demonstrated.

Of even greater interest is the nature of the antibodies formed by the maternal tissues and the manner of their transport through the placenta. There are recognized today three forms.

1. *The classical agglutinin* which agglutinates Rh positive cells in saline suspension. Called by Wiener,[2] the "bivalent antibody", they play an unimportant role[2] in the development of erythroblastosis. This antibody apparently does not cross the placental barrier for although it may be found in high titer in maternal blood, it is either absent or in low titer in fetal blood. Wiener[2] postulates that the molecule is too large to pass the placental membrane. The presence of this agglutinin in maternal blood is only significant of the degree of immunization which has occurred. There is no correlation between the titer of agglutinins and the severity of erythroblastosis which develops in the fetus.

2. *Blocking antibodies* are called by many names. Wiener[2] speaks of them as "univalent antibodies" or "glutinins". Albumin agglutinins, agglutinoids, cryptagglutinoids and incomplete antibodies are only a few of the terms encountered in the literature. These antibodies do not agglutinate saline suspended cells, but apparently coat Rh positive cells when they are exposed to serum containing these antibodies. If these cells are subsequently washed in saline and resuspended in albumin mixtures clumping occurs. Wiener[2] suggests that this univalent antibody requires the presence of a third substance akin to complement which he calls X protein. Levine[1] has demonstrated that acacia is almost as effective. Blocking antibodies are significant in that they readily enter the circulation of the fetus. The titer of blocking antibodies and the severity of symptoms of erythroblastosis are related.

Coombs[3] has made a notable contribution in the development of the anti-human globulin test. If well washed red cells from an erythoblastotic infant are exposed to anti-human rabbit serum, clumping of the cells will indicate the presence of blocking antibodies. The test may be performed indirectly by exposing first Rh positive cells to the serum of an immunized woman. If she possesses blocking antibodies, they will coat the test cells. These are then thoroughly washed in saline and exposed to the anti-human rabbit serum. Clumping will occur due to the action of the anti-human antibody on the globulin antibody. This is the indirect Coomb's test.

3. *Cryptagglutinoids* are described by Hill *et al.*[4] These antibodies hemolyze erythrocytes in the presence of complement, absorb specifically as shown by the Coomb's developing test and in most but not all cases agglutinate

* Read before the Section on Medicine of The Medical Society of New Jersey at the 184th Annual Meeting, Atlantic City, May 22, 1950.

red cells suspended in albumin and serum. They do not agglutinate red cells suspended in saline nor do they give positive blocking tests.

Wiener[2] warns that the antiglobulin reaction (Coomb's test[3]) is an agglutination reaction and if the precipitin serum (rabbit serum) contains univalent antiglobulin antibodies instead of bivalent antibodies, the test may fail. The intelligent application of the newer knowledge of univalent and bivalent antibodies is essential for the successful use of this technic. The blocking antibody is univalent, a human globulin, which coats the specific red cells. The rabbit serum containing an anti-human globulin precipitin acts upon the globulin coating the cells and causes them to clump together.

THE A AND B FACTORS

There is incomplete correlation between the titer of alpha and beta agglutinins and the ability of a serum specifically to hemolyze red cells containing the agglutinogens A and B. Some sera with low agglutinin titers hemolyze such cells and some with high agglutinin titers fail to hemolyze. Wiener[2] explains this phenomenon as due to the agglutinins being bivalent antibodies while isohemolysis is due to univalent antibodies requiring the presence of complement. Correlation between agglutinin titer and hemolysis does occur because the most potent agglutinins will usually be derived from immunized individuals and would be more apt therefore to contain strong agglutinins.

Evidence is accumulating that the A factor is capable of causing anemia through iso-immunization. Smith[5] reports a case in which chronic congenital aregenerative anemia occurred as the result of immunization against the factor A. The infant and the father were A Rh positive, the mother O Rh positive. The mother developed an anti A serum titer of 1 to 128,000. The child suffered a mild degree of erythroblastosis at birth. No other factors could be discovered which might have been related to the erythroblastosis. The fact that the child was a nonsecretor type supported the reasoning of the author that there had been iso-immunization by the A factor. Wiener and Wexler[6] report two cases of erythroblastosis due to sensitization of the mother to the B agglutinogen.

AUTO-AGGLUTININS AND AUTO-HEMOLYSINS

There is renewed interest in auto-agglutinins and more especially in auto-hemolysins. Wiener[2] believes the rise in cold auto-agglutinins reflects an increase in normal serum globulin due to non-specific irritation of the antibody forming cells. He believes that when the breakdown of red cells occurs as in sulfonamide therapy, released stromata act as antigens and induce the formation of antibodies which act on unaltered cells. This produces more hemolysis and a vicious cycle is thus set up.

Siebens *et al.*[7] studied two cases of cold hemoglobinuria. They found that a hemolysin and complement were absorbed by erythrocytes in the cold, and that a thermolabile fraction of complement was necessary for both the cold phase and the warm phase of the Donath-Landsteiner reaction. Red cells chilled in the presence of hemolysin and cyanide and then incubated with Coomb's serum were agglutinated. They considered that this was evidence that some serum factor had been absorbed on the surface of the red cell.

Singer and Motulsky[8] studied 16 cases of spherocytic hemolytic anemia. Seven cases of idiopathic acquired type and one of reticulum cell sarcoma gave a positive Coomb's test. Six cases of the hereditary type gave a negative test.

Evans and Duane[9] studied eleven patients with acquired hemolytic anemia. All the patients in this group exhibited evidence of sensitization of their erythrocytes by an antibody like agent. This antibody like agent was found absorbed on the erythrocytes when it could not be demonstrated in the serum. The occurrence of neutropenia and thrombocytopenia in some of their cases leads these authors to suspect an antibody agent in thrombocytopenic purpura.

A review of the literature suggests that a special field of immunohematology has been established.

Atlantic City Hospital

Bibliography will appear in author's reprints.

ANORECTAL DISEASE AND GASTRO-INTESTINAL DISTURBANCES *

J. Gerendasy, M.D., Elizabeth, N. J.

It is desired, in this brief communication, to draw the attention of gastro-enterologists as well as general practitioners to the variety and number of reflex gastro-intestinal disturbances caused by anorectal disease. The commonest of these is what the layman calls "indigestion", marked by a feeling of fullness or a burning sensation in the epigastrium; at times there is gaseous distress after meals with abdominal distention and flatulence. Bilious seizures associated with borborygmus and flatus are frequent complaints. A feeling of fatigue, depression, or irritability may accompany these attacks. Severe colicky pain in the abdomen with nausea and vomiting, suggesting acute appendicitis, may be present. In other instances painful gnawing sensations in the epigastrium closely simulating duodenal or gastric ulcer may occur.

These symptomatic complaints may be obtained from patients who had been told that they had ulcer or appendicitis or that the symptoms were due to emotional instability, without regard to the fact that anorectal disease conditions may cause reflex disturbances in the gastro-intestinal tract. Many of these patients were thoroughly examined by gastroenterologists and roentgenologists with negative findings. The symptoms continued because an investigation of the terminal bowel had not been performed even when the entire digestive tract had been found free of organic disease.

The reflex digestive disturbances enumerated above are usually associated with the following objective signs: coated tongue; gaseous abdominal distention; constipation, usually rectal (dyschezia) but sometimes spastic; spastic tender descending colon and sigmoid; dilated cecum and ascending colon; tenderness in the right lower quadrant simulating appendicitis but due to spasm of the ileocecal junction.

These symptoms and signs are commonly produced reflexly through the sympathetic and cerebro-spinal systems through which the anorectal region is in communication with the gastro-intestinal tract and other organs. Local foci (anal focal infection) as, for instance, hemorrhoids, cryptitis, *fistula in ano, fissure in ano* and anal abscess are the more common etiologic factors.

The result is chronic gastro-intestinal invalidism due largely to failure to examine routinely the anorectal area. That there is frequent absence of symptoms referable to the rectum should not excuse the omission of rectal examination. Local anorectal infection may produce no local symptoms. However, as in other systemic disorders, removal of the infected anal foci (cryptitis, hemorrhoiditis) will relieve the gastro-intestinal disability.

Proctologists often see long standing constipation cured by removing an infected focus in the anorectal area. Other conditions frequently relieved are various types of "dyspepsia" including ulcer-like symptoms as well as such common complaints as insomnia, irritability, apprehension, severe headaches and a general lassitude and "indisposition".

Every patient should receive a careful proctologic examination when clinical and laboratory findings do not explain the cause of severe gastro-intestinal symptoms. Reflex stimulation from diseased conditions in the terminal bowel through the vegetative nervous system produces gastro-intestinal disturbances diagnosed as peptic ulcer, irritable colon or so-called "nervous indigestion". Failure to appreciate this fact is a pitfall in correct diagnosis and effective treatment.

* Read before the New Jersey Gastroenterological Society, March 20, 1950.

956 East Jersey Street

CONGENITAL ABSENCE OF THE GALL BLADDER *

LEON E. DE YOE, M.D., and JOHN J. CASTRONUOVO, M.D., Paterson, N. J.

Congenital absence of the gall bladder is ranked fourth in rarity of biliary tract anomalies.[1] Many believe, however, that it is more frequent than the number of reported cases indicates. On collecting all available series, agenesis of the gall bladder (unassociated with other anomalies) was found in twelve of 18,350 autopsies, an incidence of 0.065 per cent.[6] Agenesis is due to the fact that the gall bladder bud fails to form from the hepatic diverticulum of the foregut or fails to develop into a tubular structure from its solid embryonic state.

The purpose of reporting this case is to focus attention on a problem which may arise at any time during biliary surgery. The pathologic physiology and treatment of this anomaly will be discussed in the light of all cases reported. Our review of the literature reveals some 75 case reports.[2,3,4] Approximately half were discovered at autopsy and half at operation. In no case was the diagnosis made preoperatively; obviously because the symptoms of biliary disease are in no way specific to the anomaly. Half the patients gave a history of jaundice. In these subjects, the common duct at operation was dilated and contained stones, usually of muddy consistency.[7] The other symptoms ordinarily associated with biliary disease are also accounted for on this basis with concomitant obstruction and ascending cholangitis. Cholecystograms usually showed "absence of a gall bladder shadow with a nonfunctioning gall bladder". Occasionally the common duct was reported to be dilated or to contain stones.[2] Intrahepatic gall bladder may be ruled out in operated cases only by cholangiographic studies during or after operation.

CASE REPORT

A 68 year-old female was admitted to the medical ward* on July 14, 1949, with jaundice of two days' duration. Present illness began with pain in the right upper quadrant radiating around the trunk to the back. She had anorexia but no vomiting. Urine was coffee-colored and stool was light yellow. One year previously she had had an attack of jaundice lasting one day with similar changes in urine and stool. Review of systems was non-contributory except that the patient was chronically constipated and required daily enemas or cathartics. There was no fatty food dyscrasia.

Examination showed bubbling rales in the lower posterior lung fields bilaterally. The liver and gall bladder were not palpable. Skin was slightly icteric. Digital rectal examination produced light yellow stool on glove. Blood pressure: 155/85; pulse: 120; temperature: 103.

Admission laboratory findings revealed icterus index of 34, nonprotein nitrogen of 76, cephalin flocculation 3 plus, increased urine urobilinogen and two plus albuminuria. Wassermann was negative. X-ray of the chest showed excessively increased hilar markings and peri-bronchial markings bilaterally.

The jaundice rapidly disappeared and patient was comfortable. Temperature dropped to normal on the second hospital day. The rales in the lungs persisted. Icterus index was normal within five days. Barium enema and gastro-intestinal series were normal. Gall bladder series on July 30 was reported as showing "faint visualization of the gall bladder". Liver function tests at this time were 4 plus cephalin flocculation and decreased hippuric acid excretion. On August 8 the patient became slightly icteric again with temperature rise to 102.8. The jaundice rapidly disappeared and the icterus index was normal one week later. A double dose of dye was given and the gall bladder series was reported as showing "very faint visualization of dye in the gall bladder".

Surgical consultation was obtained after preliminary diagnosis of chronic cholecystitis with lithiasis and common duct stone. The patient was transferred to surgery. On August 26, under spinal anesthesia, the abdomen was opened through a right subcostal incision. There were many dense adhesions in the region of the under surface of the right lobe of the liver, the transverse colon, lesser omentum and pylorus. As the adhesions were separated from the liver it became apparent that the gall bladder was absent. The common duct, portal vein and hepatic artery were exposed to the porta hepatis. The duodenum was reflected medially. There was no evidence of a cystic duct or anomalous gall bladder. The common duct was enlarged to three times normal diameter and several small stones could be palpated within it. Supra-duodenal choledochostomy was performed and several small soft brown muddy stones were removed.

A 14 french soft rubber catheter was passed distally into the duodenum and saline was injected. The proximal ducts were probed, flushed and found to be empty. The right hepatic duct was dilated and suggested possibility of intra-hepatic gall bladder. A T tube was inserted into the common duct and the abdomen was closed with drainage.

* From the Department of Surgery, The Paterson General Hospital, Paterson, New Jersey.

Postoperative cholangiogram,
35 per cent Diodrast.

Postoperatively the patient did well. She continued to drain cloudy bile. Cholangiogram *via* the T tube demonstrated patency of the ducts, no filling defects to suggest stones and no intra-hepatic gall bladder. She was discharged on Sept. 21, 1949, with the T tube left in. She was placed on bile salts and antispasmodics.

Follow-up revealed continued improvement as evidenced by weight gain and absence of symptoms. Attempts to perform the secretin test were abandoned because of skin sensitivity to the product. On October 7, a T tube specimen revealed numerous calcium bilirubin crystals but no cholesterol. The bile was becoming clearer. The T tube was clamped off during the day. Another specimen of bile on October 20 was clear yellow and microscopic examination was normal. The T tube was removed on October 28, 1949. Periodic check-up shows steady improvement.

COMMENT

Congenital absence of the gall bladder is symptomless and compatible with long life. Associated conditions causing symptoms may be: obstruction from stone, ascending cholangitis, pancreatitis or sphincter Oddi spasm.[1] Dilatation of the common duct is believed by most observers[4] to be due to obstruction rather than any compensatory mechanism. The diagnosis of absent gall bladder has never been made pre-operatively. The condition is discovered only when the surgeon cannot find the gall bladder. In such a case Bower[1] believes that the first thing to do is to examine for abnormal position of the gall bladder. It is possible[5] that a small nubbin on the common duct may be found, representing the end result of chronic cholecystitis. Should continued surgical exploration fail to reveal the gall bladder, then it must be either absent or intra-hepatic. In either case, the common duct should be explored. The incidence of stones in the common duct in this condition is high. Operative cholangiography is a valuable adjunct to rule out an intra-hepatic gall bladder at the time of operation. Needling of the liver is *not* a sure method of detecting intra-hepatic gall bladder since dilated ducts may contain large amounts of bile. Most instances of intra-hepatic gall bladder were associated with cholecystitis and it is for this reason that incision of the liver with cholecystectomy has been performed. Kehr is quoted by Walters[8] as having identified, by needling, three such cases. He removed the gall bladder with one death from postoperative hemorrhage. Fibrin hemostatics and chemotherapy together with more frequent demonstration by operative cholangiography should make removal of the intra-hepatic gall bladder a more frequent and successful occurrence. After the common duct has been explored, the T tube should be left in place for prolonged drainage until bile specimens are perfectly normal as illustrated in this case report. The T tube will also serve for postoperative cholangiographic studies.

SUMMARY

1. A case of congenital absence of the gall bladder unassociated with other anomalies is presented.

2. In the light of all case reports, the anomaly and its complications are discussed, and a plan for their management is suggested.

Bibliography appears in authors' reprints.

602 Broadway
466 Park Avenue

IODO-ACETATE INDEX IN CANCER

Samuel M. Gilbert, M.D., Samuel A. Goldberg, M.D.,
J. E. Tausz, D.Sc., and Marta Tausz, D.Sc., Newark, N. J.

Our chief hope toward the conquest of cancer seems to lie in the discovery of a simple test for it. Once such a test is positive, then a complete diagnostic survey with modern methods should detect the site of the lesion, and prompt measures for its eradication may be taken.

Since 1929 chemical means have been available[1] for the detection of the presence of some neoplasms. These include:

1. Bence-Jones proteinuria in myeloma.
2. Melanin precursors in the urine in melanoma.
3. Chorionic gonadotrophin in the blood and urine in trophoblastic tumors of the testis and uterus.
4. Ketosteroids in the blood and urine of patients with tumors of the adrenal cortex and of the interstitial cells of the testis.

Savignac, Gant, and Sizer[2] have shown that the reducing power of serum is lowered in carcinoma. They found that the reducing time of the dye methylene blue is prolonged when the serum of the patient with carcinoma is examined. Black and his colleagues report that the plasma of carcinoma patients coagulates to a greater extent than normal plasma due to increased fibrinogen. In contrast to plasma, carcinoma serum is deficient in its thermal coagulation properties.

IODO-ACETATE INDEX

Huggins *et al.*[3] recognized that in the serum of carcinoma patients the proteins are deficient in quantity and abnormal in kind. The qualitative abnormality is demonstrated by defective coagulation when the serum proteins are subjected to heat. The iodo-acetate index is a quantitative device for the recognition of the abnormality of the serum protein. Although the mechanism of the inhibition of the protein coagulation by iodo-acetate is unknown, it is fairly clear that this compound reacts to those molecular linkages essential to clot formation. The defect in thermal coagulation is not however specific for carcinoma, occurring also in certain infections. Huggins and his colleagues also found[3] that smaller quantities of iodo-acetate are required to block the thermal coagulation of carcinoma serum than normal serum. They determined the smallest amount of iodo-acetate required to prevent coagulation of the serum by heat. They use the formula:

$$\text{Iodo-acetate index} = \frac{\text{uM of iodo-acetate} \times 2}{\text{total protein in grams/100 ml. serum}}$$

and use an index of 9.0 as a dividing line. All of their 85 consecutive carcinoma patients fell into the group with an index below 9.0. In a group of 283 patients they found that *all normal patients had an index over* 9.0 and 79 of 82 patients with non-malignant pathology were over 9.0. In no normal person was the index under 9.0. The group with an index under 9 included 16 cases of non-malignant pathology, and 85 of carcinoma. However, Bodansky and McInnes[4] in repeating this work found that in a series of 68 healthy persons and 68 with non-cancerous disease and 137 patients with carcinoma it was impossible to choose a range of iodo-acetate indices that would be diagnostic. They also found that the index varied among carcinoma patients who were hospitalized and those who were ambulatory. They demonstrated that the index was lower after any operation whether for malignancy or not. They concluded that the qualitative defect in serum proteins (as revealed by the thermal coagulation tests) is not specific for carcinoma but merely one manifestation of the reaction of the organism to noxious stimuli.

Pollak and Leonard[5] checked the indices of 250 patients. They found 73 correct positives, 7 false negatives (in proved carcinoma) 147 correct negatives, and 23 false positives. They arbitrarily used 9.70 as the maximum correct positive. They concluded that the procedure

1. Huggins, Charles: Cancer Research, 9:6 (June 1949).
2. Savignac, R. J., Gant, J. C., and Sizer, I. W.: A.A.A.S. Research Conference on Carcinoma, 241:1945.
3. Huggins, Charles, Miller, Gerald M., and Jensen, Elwood V.: Cancer Research, 9:3 (March 1949).
4. Bodansky, Oscar, and McInnes, George F.: Cancer, 3: (Jan. 1950).
5. Pollak, O. J., and Leonard, Adeline: Journal of the American Medical Assocation, 142:12 (Mar. 25, 1950).

was not a suitable diagnostic test because of too many errors.

We have reviewed in this series 129 patients. The tests were all done by Tausz and Tausz according to the technic of Huggins, Miller and Jensen[6] and their simplified method as later published by these same authors.

Dilutions of iodo-acetate in buffer solutions are made containing 18039 micromols of iodo-acetate. To 0.5 millilitres of serum in a Wasserman tube 0.5 millilitre of each dilution is added. These mixtures are placed in a water bath for 30 minutes. The test tubes are allowed to cool and are then tested for solidification according to the method specified by Huggins *et al.*[3] If the contents flow down the tube (which is inverted at a 45 degree angle) as a liquid or a shapeless mass the content is read as "liquid". If the contents remain in the end of the tube or slide down as a solid mass the contents are read as "solid". Some practice is necessary to distinguish between the two stages. We found it helpful to count the number of drops formed when the contents flow from the inverted tube. More than three drops indicate that the contents are liquid while the formation of only one or two drops may be caused by the breaking up of the solid mass during its transit down the inverted tube.

RESULTS

In our series of 129 cases we had 78 cases of non-malignant disease. In 45 of these, we found the index correctly positive, that is over 9.0 (see table 1). However, in 33 cases (see table 2) the index was under 9.0 giving us a false positive in 42 per cent of our cases of non-malignant disease. In 25 cases the blood was taken from donors for transfusion; these were all checked for the presence of communicable diseases. In 23 of these, the index was correctly negative (over 9.0) and in two, the index was under 9.0. In our series we had 26 proved cases of malignancy (24 carcinoma and 2 lymphosarcoma); in 22 cases the index was correctly positive (under 9.0) and in four cases* the index was falsely negative or over 9.0. In the case of lymphosarcoma the index was 9.6, in the breast cases 11.0 and 12.6, and in the colon carcinoma 11.1. This gave an error of 15 per cent.

COMMENT

In table 3 our findings are tabulated according to the various groups of cases. It is apparent from the results in our series that the test may be correctly positive in 85 per cent of cases of carcinoma. However, the large ratio of false positives in non-malignant conditions makes the test nonspecific and therefore of little clinical help in doubtful or early cases of malignancy where we hope to be able to offer the patient the best opportunity for cure. Finding an index of less than 9.0 in a patient being screened for malignancy would not be diagnostic of neoplasm since in our series 42 per cent of noncancerous cases had an index below 9.0. The test might be helpful if the index were repeated in a given individual at yearly intervals. Then a significant drop between two yearly observations would indicate the need of a most thorough diagnostic study and lead to the finding of pathology whether malignant or not. This theoretical application will need further confirmation.

TABLE 1.

IODO-ACETATE INDEX OVER 9.0

Chronic cholecystitis with stones (6 cases)
Functional gastro-intestinal disorders (17 cases)
Bleeding duodenal ulcer
Coronary thrombosis
Diabetic acidosis (2 cases)
Essential hypertension (2 cases)
Thyrotoxicosis
Bronchial asthma
Gastric ulcer
Ventral hernia
Incomplete abortion
Nephrolithiasis (3 cases)
Aplastic anemia
Glaucoma
Pregnancy—normal
Fibromyomata uteri
Pulmonary tuberculosis
Arteriosclerotic heart disease
Benign prostatic hypertrophy
Fractured leg

TABLE 2.

IODO-ACETATE INDEX UNDER 9.0

Chronic cholecystitis (index 7.7)
Perforated duodenal ulcer (index 7.0)
Coronary thrombosis (index 8.06 and 8.0)
Exophthalmic goiter (index 8.0)
Pyonephrosis with nephrolithiasis (index 7.0)
Macrocytic anemia probably pernicious anemia (index 7.8)
Cardiac failure; 2 cases (index 7.0 and 5.7)
Pregnancy before term—3 normal cases (index 6.4, 6.8, 7.6)
Cellulitis of foot (index 5.0)
Pellangrini's disease of knee (index 8.00)
Diverticulosis of colon (index 8.2)
Incomplete abortion—early pregnancy (index 6.6)
Aplastic anemia (index 6.4 and 7.7)
Appendiceal abscess and diabetes (index 6.0)
Osteomyelitis of toe (index 8.8)
Empyema of gall bladder (index 7.3)
Fibromyomata uteri (index 6.4)
Pancreatitis (index 8.7)
Diabetes mellitus (index 7.2)
Hypertensive cardio-renal disease (index 6.3)
Cerebral embolism (index 8.9)
Functional gastro-intestinal disorder (index 7.7)
Prostatic obstruction-benign (index 8.3)
Bronchiectasis (index 8.2)
Ulcerative colitis (index 7.6)
Multiple sclerosis (index 6.3)
Gastric neurosis (index 8.5)
Rheumatic Arthritis (index 8.5)

6. Huggins, Charles, Miller, G. M., and Jensen, E. V.: Cancer Research, 9:3 (March 1949).

* Including two advanced carcinomas of the breast, one of carcinoma of the hepatic flexure of the colon, and one case of lymphosarcoma.

TABLE 3.

	Number of cases	Index 9.0 or less	Index 9.1 or over	Percent error
Normal Donors	25	2	23	10%
Cancer cases	26	22	4	15%
Non-malignant disease	78	33	45	42%

SUMMARY

The iodo-acetate index test of Huggins *et al.*[3] has been studied in 129 patients. In 25 normal donors the test gave a 90 per cent correctly positive result. In 26 proved carcinoma cases, 85 per cent were correctly positive. In 78 cases of non-malignant diseases there were 42 per cent false positives. It is the latter group of findings that make the test less valuable as a diagnostic test for malignancy.

144 Clinton Avenue

MULTIPLE MYELOMA

REPORT OF A CASE

Curt Bluefeld, Jr., M.D., Nutley, N. J., Robert H. Ringewald, M.D., and Sau Fong Cheung, M.D., Englewood, N. J.

According to the present generally held conception, multiple myeloma is a uniformly malignant fatal disease ranging from the solitary bone nodule to the acute leukemic phase at either extreme. The following case illustrates the widespread involvement of systemic organs in addition to involvement of the bones.

A 48 year old Negro male, was admitted to Englewood Hospital on July 29, with a complaint of low back pain of two months' duration. This pain, on occasions, became quite severe, radiating down the posterior aspects of both thighs. Since onset, he had noted progressive weakness, bleeding from the gums, frequent nose bleeds, urgency, frequency, and nocturia. On admission his temperature was 99, pulse 100, and blood pressure 128/98. The patient was a well developed, fairly well nourished middle aged male appearing chronically ill, but in no acute distress. The left eye had an ovoid pupil with a membranous cataract. The right pupil was round, regular, and reacted to light; the fundus showed choroidal and retinal hemorrhages. There was no evidence of bleeding from the nose. The tongue was pale with smooth edges, the teeth were poor, and the gums were spongy and bleeding. There was dullness at both lung bases with a few cracking râles. The heart was negative. Hepatic dullness was percussed down two fingers below the right costal margin, but the edge was not felt. The spleen was not palpable. Except for a few shotty bilateral inguinal nodes, there was no lymph node enlargement. Rectal and neurologic examinations were negative.

There was a marked anemia with 1.4 million red blood cells and 3.2 Grams of hemoglobin. It was impossible to do red cell counts after several days because of clumping of the red cells and rouleaux formation. White blood cell counts averaged 6000 with as high as 13 per cent plasma cells in the peripheral blood. Serum proteins showed a marked hyperglobulinemia, the highest total value being 15, with 1.33 albumin and 13.67 globulin. Serum calcium ranged from 10.7 to 14.5 serum phosphorus varying from 4.0 to 6.0. Prothrombin times showed a persistent elevation of from 7 to 10 seconds above the normal control in spite of administration of vitamin K. Platelet counts averaged 110,000; bleeding and clotting times were normal on admission and were only 5.5 minutes and 8 minutes respectively just before death. Sedimentation rates (corrected Wintrobe method) ranged from 0 to 7 millimeters per hour. Bence-Jones protein was present in the urine on three occasions. Sternal marrow examination revealed 30 per cent plasma cells. The Kline was negative, thymol turbidity 0.4 units, cephalin flocculation 1 plus after 48 hours, blood sugar was 82. Phenolsulphonephthalein test showed only 25 per cent of the dye excreted after 2 hours. Terminally the total nonprotein nitrogen began to rise, reaching a peak of 80 shortly before death.

Roentgen examination revealed old pathological fractures of the tenth and eleventh ribs on the left side. The spine showed many small "punched out" areas in both the thoracic and lumbar regions. Skull x-rays were normal.

His course in the hospital was progressively downhill. He received several blood transfusions with only temporary benefit. Bleeding from the nose and gums became troublesome, and hematomas developed at the site of each needle puncture. Weakness became extreme and the patient developed a bronchopneumonia probably secondary to aspiration of blood from the nasopharynx. Death occurred on the 31st hospital day.

Autopsy: The body was that of an emaciated middle-aged Negro male. There was a cataract in the left eye. The heart was essentially normal.

Posterior parts of both lungs were dark red and airless, exuding a great deal of dark red bloody fluid. The spleen was enlarged, weighing 260 Grams. Its capsule was gray and smooth; the consistency firmer than normal. On section the color was a uniform gray red. The kidneys were of normal size; the capsule stripped with ease. Occasional small hemorrhages were seen over the cortex, and on section the cortex had a yellow tint, while the medulla was a bluish red color. The liver weighed 1940 Grams. Its capsule was smooth and the consistency was normal; on section the liver was yellow brown. Gall bladder, adrenals, and pancreas appeared normal. The urinary bladder mucosa showed many hemorrhages. The prostate was normal, as was the gastro-intestinal tract. Sections of several ribs, the sternum, and the vertebrae revealed the bone marrow to be a grayish red color, and in some areas the cancellous bone appeared to be invaded by the marrow.

At *histologic examination*, several small deposits of plasma cells were found in sections of the heart. Lung alveoli were filled with edematous fluid, red cells, leukocytes, and masses of bacteria. Plasma cells were seen throughout the sections of the spleen, both diffusely and in small foci. The liver showed many plasma cells in the sinuses and small foci of plasma cells in the periportal areas. The kidneys revealed only passive congestion with some arteriosclerotic changes. Many small foci of plasma cells were found in the medulla of the adrenals. All bone sections showed marked replacement of the normal bone marrow by plasma cells. This process was diffuse throughout the bone marrow.

Numerous authors have stressed the relationship of diffuse multiple myelomas to the lymphatic and myelogenous leukemias. This becomes even more apparent when one considers the fact that many cases of multiple myeloma have shown plasma cells in the peripheral blood. The findings in our case (plasma cells in the liver, spleen, heart, and adrenals, as well as in the bone marrow) indicate the diffuse nature of this disease and in our opinion suggest that multiple myeloma is not necessarily a pure bone disease, but is a generalized process arising from the cells of the bone marrow and capable of involving many other organs.

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Nutley, N. J.

GOING MY WAY?

"No one goes alone.

"You feel it when trouble strikes a member of your family. When whole families get into trouble your community feels it. *Give generously.* The Family Service in your town is supported by the Community Chest, and it trains workers to help families in trouble. What you send into the homes of others through a gift to your Community Chest and its Red Feather Services come back into your own."

BING CROSBY

ONE HUNDRED YEARS AGO

REPORT (1849) FROM THE EASTERN DISTRICT: "In Newark we have several quacks who, not content with regulating their practice by Jahr's *Manual*—that most ethereal of romances—implicitly limit their knowledge by it. Dr. N- who was, till lately, a dentist, pushed himself out on the full tide of sugar practice by one year's study of the *Manual*. During the process of bandaging a lying-in patient, he asked with a King George wonderment* if the striae (which marked the abdomen from a former pregnancy) were caused by a blister! Now the question is, how shall we check the popular frenzy which bears these cheats on to fortune? Let us not be mealy mouthed. Are we firm in the conviction that this quackery is but an impudent imposition? Then let us avow it boldly in the face of friend or foe. Let us refuse all courtesy to its ministers! Let us scent out and hunt as with a hound's keenness this foul monster of quackery till it slink from the vicinage of civilization to the companionship of that superstition that flourishes in murky heathendom." (From pages 440-441, 1849 *Transactions of The Medical Society of New Jersey.)*

* After considerable antiquary research, your editor has been unable to find anywhere in print a definition of "King George Wonderment". Probably it refers to King George III, who had died just two decades earlier and who was known to have had periods of mental incompetency. Presumably then, "King George Wonderment" is a fatuous or idiotic questioning.

BANTHINE* IN THE CONTROL OF DUODENAL ULCER

A. I. Friedman, M.D., Hackensack, N. J.

The search for an oral medication that will reduce the cephalic phase of gastric secretion has been spurred by the return of vagus resection (vagotomy) to the surgical armamentarium. Early enthusiasm for vagotomy has now subsided because of technical operative difficulties and postoperative complications. However, it remains a useful auxiliary to surgical therapy. The cephalic phase of gastric secretion, controlled by the vagus is considered by many (Babkin,[1] Dragstedt,[2] etc.) to account for up to 80 per cent of the entire production of hydrochloric acid and pepsin. If it can be inhibited orally and the old dictum "no acid, no ulcer", remains in force, the discovery of such a remedy will indeed be worth while. Most therapeutic efforts heretofore have been directed towards the *neutralization* of acid formation. The advantages of acid *inhibition,* centrally, are obvious.

Currently, considerable re-emphasis has been given the concept that the motor disturbances of the upper gastro-intestinal tract are the most important factors in the production of ulcer distress.[3] The beneficial effects of vagotomy in peptic ulcer are presumed to be the result of inhibition of intestinal motility and spasm.

Whether one or both interpretations are correct, an adequate *medical* vagotomy has tremendous advantages over other methods of therapy. Banthine* may provide such a method. Preliminary pharmacologic studies[4] have been extensive; clinical investigation in man has been reported only meagerly[5] thus far.

Banthine* in small doses in animals prevents transmission of impulses through the parasympathetic nervous system *via* an atropine-like post-synaptic block at the post-ganglionic nerve endings i.e. in the gastro-intestinal tract at the plexuses of Meissner and Auerbach. In large amounts, it blocks sympathetic as well as parasympathetic ganglionic transmission. In man, using clinical test doses, parasympatholytic effects were most prominent. The effects on sympathetic synaptic block were minimal. These neuro-physiologic effects were reflected in the gastro-intestinal tract by diminution of peristalsis with delay in gastric emptying, decline in gastric acidity and reduction in intestinal motility.[5] Its use, therefore, as an anticholinergic, vagus inhibitor of the gastro-intestinal tract seems rational.

This preliminary report concerns the adminstration of Banthine* to 14 patients with duodenal ulcer and one with gastric ulcer. All of these patients have characteristic x-ray lesions either with ulcer craters or with chronically deformed duodenal bulbs and have been confirmed in their diagnoses. The only untoward complaints were considerable xerostomia in about 70 per cent of the cases and marked bitterness of the tablet, an opinion in which all the patients concurred. One patient complained of cycloplegia and one suffered from slight urinary retention not serious enough to discontinue medication. No toxic phenomena were noted. All of the patients received at least three 100 milligram tablets of Banthine* daily, fifteen minutes before meals. Some were given one additional tablet before bedtime for nocturnal distress. No other medication was permitted during the one month period under investigation. A bland diet with frequent feedings was given to all. Each patient was requested to complete a chart during the month with daily notations of pertinent signs and symptoms, to be followed by a general comment at the end of the trial period. Two other patients with duodenal ulcer were unable to complete their month's medication

* Banthine is the G. D. Searle Company's registered trade name for an orally administered preparation of beta di-ethyl amino-ethyl xanthine carboxylate methobromide. The supply used in this project was generously furnished by Dr. I. C. Winter of Searle and Company whose cooperation is gratefully acknowledged.

1. Babkin, Boris P.: *Secretory Mechanism of the Digestive Glands.* 2d edition. Hoeber, New York, 1950.

2. Dragstedt, Lester. *et al.*: Paper on "Phases of Gastric Secretion", read at Annual Meeting of the American Gastro-Enterological Association, April 29, 1950.

3. Necheles, H.: American Journal of Digestive Diseases, 16:237 (July 1949).

4. Grimson, K. S. *et al.*: Journal of The American Medical Association, 139:154 (January 15, 1949).

5. Longino, F. H. *et al.*: Gastro-Enterology, 14:301 (February 1950).

because of unrelated intervening illness. All of the patients in this series were males.

This series with Banthine* concerns peptic ulcer only but it is being used concurrently in other gastro-intestinal disturbances that will be reported on later. One woman with rectosigmoid diverticulitis was given Banthine.* She had, in addition, cholelithiasis of many years' duration. One week following the administration of the drug, she developed a recurrence of right upper quadrant pain, this time associated with hydrops and obstruction in the cystic duct. A cholecystectomy was performed. It is questionable whether Banthine* influenced this development, but in view of its effect on smooth muscle this must be considered.

The results of this project are displayed in the table.

TABLE[6]

EFFECTIVENESS OF BANTHINE* ON SYMPTOMS

Case No.	Pain	Pyrosis	Night Pain	Poor Appetite	Patient's Appraisal
1.	R	R	O	I	Excellent
2.	S	S	W	I	Worse
3.	I	I	O	I	Better
4.	S	W	S	O	No effect
5.	O	I	O	I	Better
6.	O	S	I	I	No effect
7.	S	I	I	I	Good
8.	O	I	O	O	No effect
9.	W	W	O	W	Worse
10.	I	I	O	W	Better
11.	I	I	I	S	Better
12.	O	I	O	O	Better
13.	O	S	I	O	No effect
14.	O	I	O	I	Good
15.	I	I	I	S	Good
Total improved	5/9	10/15	5/7	7/10	9/15

Patient No. 1 had abdominal pain and distress of one year's duration. He had been x-rayed twice in other locales without any diagnosis. Following the identification of a gastric ulcer on the lesser curvature below the incisura, he was put on Banthine* and a dietary regime. Two days later he was without symptoms. X-ray one month later failed to reveal any lesion.

Patients No. 2 and No. 11 have associated hiatus hernia. *Patients 5, 7, 11 and 14* had demonstrable ulcer craters in the duodenum visualized by x-ray within the last month. *Patient No. 7,* in addition, had tarry stools. Review x-ray of *patient 14* three weeks later failed to reveal any ulcer crater.

All the other patients had been treated for periods of one to four years with a bland diet, frequent feedings, antacids, belladonna and phenobarbital, prior to trial of Banthine.* Most have been comfortable. *Patient No. 15,* however, has been an intractable ulcer case for several years. One year ago, he had been scheduled for surgery but refused despite continuous abdominal discomfort, pain, et cetera. Seven days following the use of Banthine* he was relieved of all complaints except some belching. This man, a tense, intelligent patient, was enthusiastic about the new medication.

COMMENT

A trial period of one month is very short in the life history of chronic gastro-intestinal affections yet certain observations are apparent. In the one case of gastric ulcer, and in the four acute exacerbations of duodenal ulcer, the effects of Banthine* were good to excellent. The relief of pain appeared to be the most striking manifestation of the drug. Where the ulcer lesions were chronic (clinical and radiologic evidence) results appeared to be indefinite. Appetite appeared to be improved in most.

Reduction in gastric acidity was observed in only one of the three cases where studies were made. Longino *et al.*[5] have shown a marked reduction in free acid, from 1.19 to .28 milliequivalents fifteen minutes following the administration of Banthine* in patients with duodenal ulcer.

The x-ray afforded the most remarkable evidence of the effectiveness of Banthine.* Delay in gastric emptying up to seven hours and marked inhibition of intestinal motility, following a barium meal, were routine phenomena.

No cases of gastro-jejunal ulcer were available for trial. Here, certainly, a vagolytic drug should be beneficial.

CONCLUSIONS

1. Banthine* (SC 1703) a new parasympatholytic quaternary amine was used in 15 cases of peptic ulcer.[7]

6. The symbols are read as follows: I, improved; O, did not have this symptom; R, complete relief; S, same; W, worse. Case 1 was a gastric ulcer. The other fourteen patients had duodenal ulcers.

7. Since the acceptance of this paper seven additional peptic ulcer patients have been studied. The relief of pain, probably due to the inhibition of hypermotility (spasm), still remains the most striking manifestation of the drug. Healing of the ulcer, generally, does not appear to be influenced.

2. Patients with gastric and duodenal ulcer showing active ulcer craters respond very favorably to the oral administration of Banthine.* Relief of pain was a prominent feature.

3. Patients with chronic duodenal ulcer without clinical or x-ray evidence of acute activity had variable benefits. Most were *not* benefited. Two appeared to be worse. One appeared greatly relieved.

4. Preliminary results in the use of Banthine* suggest that it has a useful place in the treatment of peptic ulcer. However, more extensive clinical investigation and more thorough follow-up are necessary to evaluate the proper application of this drug.

405 State Street

GASTRO-ENTEROLOGIC CONVENTION

The National Gastro-enterological Association will hold its Fifteenth Annual Convention and Scientific Sessions at the Hotel Statler in New York City October 9 to 11.

Among the outstanding speakers at the convention will be: Dr. Richard B. Cattell, Lahey Clinic; Dr. W. Stuart Harrington, Mayo Clinic; Dr. W. J. Merle Scott, Rochester, N. Y.: Dr. John B. O'Donoghue, Chicago; Dr. Maurice Feldman, Baltimore; Dr. Edward T. Lewison, Baltimore.

The Annual Banquet of the Association will be held at the Hotel Statler on Tuesday evening, October 10, 1950.

Immediately following the convention, the Association is conducting a course in graduate gastro-enterology at the Hotel Statler in New York City, October 12 to 14.

Further information concerning the program and details of the course may be obtained by writing to the National Gastro-enterological Association, 1819 Broadway, New York 23, N. Y.

FIFTY YEARS AGO

At the 1899 Annual Meeting of The Medical Society of New Jersey, Dr. A. W. Taylor of Beverly, N. J., read a paper entitled: *Circumcision, Its Moral and Physical Necessities.* The following extracts of that paper are taken from pages 187 to 191 of the 1899 TRANSACTIONS:

"No surgical operation can boast of so ancient a history as circumcision. It is 3797 years old. The first subject was a man 99 years old, the second his son of 13. After which, all the males of the neighborhood vied with one another to follow the example of the patriarch, thus showing a different spirit from the foxes in the fable of Aesop when one of their number had been accidentally curtailed. . . Domestic infelicity is often caused by phimosis interfering with the performance of the marital function. Circumcision of the husband would often do more towards producing domestic harmony than the disgusting divorce suits* which drag their slimy length through our courts. There are many cases of mental depression and moral disturbances where the cause of the trouble lies at the glans. A sharp bistoury and a few stitches would roll off a burden of sorrow and sin as quickly as Bunyan lost his. As a means of retaining syphilitic poison, an elongated foreskin is an active factor. Circumcision has also relieved convulsions and restored health where other treatment has failed."

* In 1899 when this was written, the divorce rate was 7 per 10,000 population; it is now 44 per 10,000. In Dr. Taylor's day, one marriage in twenty terminated in divorce. It is perhaps fortunate that Dr. Taylor did not live to see the present ratio: one marriage in four.—Editor.

CLOSED BRAIN INJURIES

Felix Frisch, M.D., Trenton, N. J.

If there is no skull fracture or scalp laceration, the physician tends to dismiss a head injury as "only a concussion". He usually gives a favorable prognosis, discounts the need for further neurologic study, and assumes that any subsequent neuropsychiatric complaints are due to a "traumatic neurosis". It is true that a psychoneurosis may be lighted up by a head trauma. This is related more to the patient's basic personality than it is to the nature, severity or site of the injury. But it is naive and hazardous to assume that all headaches, dizzy spells, irritability, weakness, et cetera, following head trauma are of neurotic origin. As a matter of fact, neurotic factors frequently complicate organic neurologic effects of brain damage, and it takes a good deal of judgment to disentangle the emotional from the structural components.

The brain is a soft, incompressible, fragile mass floating freely within a spacious skull cavity. One is not surprised, therefore, that it is often damaged in head injury. When struck, the skull moves faster than the brain because it is lighter and better pivoted. As a result the fast-moving inner edge of the skull may come into contact with the lagging brain. Again, the brain may be hurled against the opposite side of the skull and bounce back, because it does have a certain resiliency. In view of this very common and very real kind of damage, it is foolhardy to dismiss closed brain injuries lightly. At least four elements of the brain may be affected: (a) The vessels, (b) The meninges, (c) The fluid, or (d) The brain parenchyma itself.

(a) Vascular system: In almost every head injury, there will be numerous, small petechial hemorrhages scattered through the brain. Even in minor damage, capillaries and venules are torn. Sometimes the vascular damage is localized to the pons, the basal ganglia, the medulla or elsewhere, producing delayed focal symptoms. Contre-coup effects may produce contusions, often leading to copious bleeding into brain tissue. Intracerebral, subarachnoid, and subdural hemorrhages may occur, and sometimes swift surgical intervention is necessary to save life.

(b)—The meninges. A meningeal hematoma may form, organize, and be replaced by connective tissue. This scar means an adhesion which is certain to affect brain function.

(c) Fluid changes. In even the mildest concussion, some degree of cerebral edema is present. This edema aggravates the clinical symptoms and may slow down recovery. It should be distinguished from the later, and more serious, traumatic hydrocephalus, which may be responsible for stubborn and often mysterious subjective symptoms.

(d) The brain parenchyma will suffer if there is cerebral laceration. This laceration is eventually replaced by a scar which naturally affects cerebral function-depending on the site and size of the scar. Necrotic brain tissue eventually becomes a nonfunctioning, irritating mass of glial-connective tissue. In almost every head injury, some of the brain's myriad cells are likely to be vacuolized or liquefied.

CLINICAL PICTURE

There is no necessary relationship between the severity of the injury and the patient's course. Patients have died after apparently "trivial" head injuries, and no adequate lesion was discovered at autopsy. And I have seen patients survive after extensive brain laceration. The principal diagnostic and prognostic signs are these:

1. *Unconsciousness:* Unconsciousness, no matter how soon or how delayed after the injury, no matter how slight or how profound the impairment, should alert the physician to the fact that something pathologic must have happened within that skull. Sometimes the fact of unconsciousness is missed because bystanders stated that the man seemed to be awake all the time, and because the concussion-amnesia wiped out the patient's own recollection of the suspension of his consciousness. Sometimes the patient appears wide-awake, yet does not answer questions well: a phenomenon which is too readily ascribed to "confusion" but which, in fact, usually means *traumatic stupor.* As a rough rule of thumb, it may be said that the longer the period of impairment of consciousness (including periods of stupor and "confusion") the more grave the outlook.

2. *Confusion* may consist of simple dis-

orientation, such as the traditional "Where am I?" remark. Or it may spell out violence and delirium. This too, signals some pathologic process in the brain and is not to be dismissed lightly.

3. *Amnesia.* In examining a head injury case, the practitioner should test for memory defects. This step is too often omitted. Commonly the patient says: "I don't know what hit me" which is evidence of amnesia *at the time* of the impact. Careful questioning will often elicit the baffling phenomenon known as "retrograde amnesia"—a loss of memory for events *preceding* the injury. This possibility is important where legal action, either civil or criminal, is involved. The patient's insistence that he does not recall the events leading up to violence is often perfectly true, though many investigators, lawyers and judges find it incredible that a head injury at 11 p. m. should wipe out memory of events that had occurred at 10 p. m. Yet it can happen and retrograde amnesia is well supported by cases in the neurologic literature. Sometimes the patient behaves adequately, often with apparent poise and good judgment, at the time of the accident. Hence it is assumed that there was no memory impairment. This is an unwarranted assumption. The lower automatic, danger-averting, danger-reacting, reflexes may function quite well even though higher intellectual functions are badly impaired. Another source of confusion is the honest glibness with which some patients fill in the gaps in their memory. They reconstruct the accident, either from the remarks of others, or out of innocent fabrications of their own, thus producing a false picture of preserved memory.

4. *Headache, nausea and vertigo* are the common sequalae and need no further discussion wih a medical audience.

5. *High temperature combined with slow pulse* is suggestive of hemorrhage into the ventricles. The resulting irritation causes fever, while the pressure on the brain produces bradycardia. The alert examiner always records both the pulse and the temperature and notes any inconsistency here.

6. *Later symptoms.* After a few days the patient may feel well, and clamor for discharge from the hospital. Delayed symptoms must now be considered. Headache, photophobia, memory disturbances and impairment in ability to concentrate may be enduring symptoms. In some cases, there is a specific change in personality: irritability, argumentativeness, depression, moodiness, intolerance, explosiveness of temper and marked self-centering are the occasional sequelae. Mental deficiency is rarely caused by head injury, but in children at least, the possibility of post-traumatic intellectual impairment must be seriously considered. Special attention must be given to the possibility of jacksonian epilepsy or other forms of traumatic convulsive disorder.

7. *Post-traumatic convulsions* are usually slow to develop. Indeed, the time between the injury and the convulsions may be so long as to suggest only a coincidental relationship. However, organic post-traumatic convulsions usually result from adhesions or scars and these take time to develop.

CLASSIFICATION OF LESIONS

The problem of head injury is haunted by semantic as well as by medical confusion. In an effort to align the clinical with the pathologic picture, I use the following scheme of classification:

(A) Shock. In every head injury there is, at least momentarily, an impairment or cessation of function which must be described as a form of shock, analogous to the depression of vital centers which occurs in severe injuries elsewhere in the body. As with other cases of shock, it may be serious enough to cause immediate death without leaving any trace of a structural lesion. Circulatory disturbance within the skull always occurs, to some degree, and this is presumably the physiologic basis for the shock.

(B) Concussion. While the meaning of this term is still controversial among neurologists concussion —(especially when the patient was unconscious for any time)—means in my opinion* always a structural lesion: cell damage, minute hemorrhages, fragmentation of neurofibrils and cerebral edema.

(C) Contusion. A contusion is a bruise of the cortex with copious effusion of blood into the adjacent tissue. It is often overlooked because it may

* In court, insurance and claims cases, the word "concussion" is generally limited to head injuries producing unconsciousness *without* any structural lesion. Dr. Frisch's definition is thus at variation with the more generally accepted use of the term. The author believes that structural damage does exist, even though it may not be clinically demonstrable.—*Editor.*

not be immediately apparent on cursory examination. The oversight may be fatal.

(D) Laceration. A laceration of the brain is like a laceration of the skin: an actual split in the tissues. Mowever, since the brain is, above everything, an organ of conduction by continuity of fibers, a laceration in the brain severs functional as well as structural unity, and leads to impairment of brain activity. Lacerations and contusions are more likely to occur on the base than on the convexity of the brain because of the jagged nature of the bone surface along the base of the skull. Since symptoms may be delayed, lacerations may be overlooked and the results may be serious or fatal.

PROGNOSIS AND MANAGEMENT

Before appraising prognosis, the examiner should weigh all the possibilities above listed. As examples, let us consider the following actual cases:

1. An accident case is brought to an emergency room by ambulance; a short time afterwards the patient seemingly regains consciousness (being able to give his name and address). The intern does not find any sign of scalp injury or fracture of the skull. After a short rest he dismisses the patient: "You may go home, nothing happened to you". This is a hazardous error in judgment. If there is no occult bleeding going on yet it might start any moment afterwards; second, as there is almost certainly some brain edema present, the patient may collapse if not appropriately taken care of.

2. The state of unconsciousness passing away, the patient becomes restless. In 99 per cent of the cases, the intern will grasp at the syringe and give a hypodermic injection of morphine. This is a risky procedure. Edema as well as intramedullary hemorrhage are depressors of the vital centers; by administering so potent a depressor as morphine, the tolerance threshold can easily be exceeded and respiration and circulation might suddenly stop. Apart from this danger, it is unwise because it blocks our most important approach to diagnostic insight: it contracts the pupils artificially. But the width, equality and reactions of the pupils are essential parts of the clinical evidence.

The right procedure in the first example (if the patient cannot be kept in the hospital) is to send him home by ambulance with an order to stay in bed and to call his physician. In the second case, if sedation is needed, bromides should be administered if the patient is fully conscious. If he is still dazed phenobarbital sodium should be given intravenously or intramuscularly, six to ten grains.

Every patient with a head trauma, especially if he was unconscious for any time, should be subjected to a spinal tap; first releasing a small amount for diagnostic purposes (occult hemorrhage, pressure et cetera). If the pressure is found increased at a later time, a larger quantity should be drained off. This is especially desirable after post-traumatic hydrocephalus has developed. In such a case it is even good to combine the fluid drainage with an air insufflation, provided there are no other complications.

In all cases with positive or dubious signs of brain concussion a neurologist and an ophthalmologist should be called. All patients with brain concussion should be examined by electroencephalography after an interval of several weeks or months has passed. Failure to do electroencephalography is inexcusable. The electroencephalogram is, for the time being, an excellent, frequently even the only means to get information on brain function after a head trauma. It is often startling what abnormal records can be obtained from patients who are moving around and are trying to do their jobs. These patients should not be permitted to resume their usual activities without having had a very strict and prolonged period of rest. A positive electroencephalogram is a definite sign of *traumatic encephalopathy.* We have no other way of treating these patients except with complete rest from mental and physical exertion as long as possible.

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HENRY FORD II

THE CLINICAL USE OF BALLISTOCARDIOGRAPHY*

Max Greenberg, M.D., Linden, N. J.

When a heart shadow is visualized under the fluoroscope, inward and outward motions are noticed. Lateral movements, too, are observed on its lateral axis. On very careful observation, up-and-down motion can also be seen. These up-and-down excursions of the heart are more easily observed in the interventricular groove, and in hearts with calcified valves,[1] especially the aortic valve. During World War I, up-and-down motion, of one to three centimeters, had been noticed in wounded soldiers who had pieces of shrapnel embedded in the interventricular septum.

These various excursions of the heart are the product of the pulsations of the heart muscle, the systolic and diastolic activity and rest, and the impact of the surging blood against the walls and valves of the heart's chambers. In the same way movements are also imparted to the great vessels and the entire peripheral circulation.

It is considered that the body recoils in response to these impacts just as a gun "kicks back" after it is fired. These forces are known as "ballistic motions". For years the up-and-down movements of the heart have been recorded by many observers with complex apparatuses. The records were elaborately analyzed[2] with the hope of arriving at a formula that would permit calculation of cardiac output.

In 1905, Yandell Henderson[3] used a swinging table, and a set of records to measure ballistic movements. On an expedition to Pikes Peak, in 1913, Douglas[4] attempted to determine the "relative size of the heart beats" in an individual at different altitudes. Members of the expedition were placed on a plank supported on rubber stoppers and the movements were recorded on a smoked drum. In 1922, Heald and Tucker[5] used a diaphragm from a drum on which the subject stood. They demonstrated increased amplitudes after exercise, nitroglycerine, and in patients with aortic regurgitation.

In 1928 Augenheister and Lau[6] placed their subjects on a rigid table and made records with a seismograph. These graphs were similar to those obtained by Starr, Rawson, Schroeder and Joseph[7] in 1939, which is the curve commonly accepted today. In 1933, Abramson[8] sat his subjects on an aluminum chair suspended from steel springs and recorded the movements photographically. The curve he obtained also resembled Starr's.[2] From these curves he developed a formula for measuring cardiac output, but this formula was not very dependable.

Starr, Rawson, Schroeder and Joseph[2] in 1939 first made a freely swinging table, with a lever and a kymograph system for recording, but abandoned it soon for a new table which, "opposed longitudinal motion by a strong steel spring, a change which has abolished interference due to movements or normal respirations". They used optical methods of magnification for recording. Except for the fact that the apparatus was cumbersome and expensive, ballistocardiography from now on became an accepted method for measuring cardiac activity. Starr[2] developed a formula to measure cardiac output from this standard curve, and also established the validity of the curve as it is now used.

Many workers became busy with ballistocardiography after the stimulus of Starr and his co-workers, and a fruitful period followed with work by Brown, Rawson, Nickerson, Hamilton, Dock and many others who helped to establish ballistocardiography as a useful tool for the diagnosis of cardiac ailments.

The apparatus used in most instances was cumbersome, space consuming and costly. Ballistocardiography became possible as a laboratory procedure but not for every day clinical use. Recently, however, smaller and less ex-

*Read by invitation before the joint staffs of cardiology departments of St. Elizabeth and General Hospitals, Elizabeth, New Jersey, April 27, 1950.

1. Schwedel, John B.: Annals of Roentgenology, 17:65 (1948).
2. Starr, Isaac, Rawson, A. J., Schroeder, H. A., Joseph, N. R.: The American Journal of Physiology, 58:1 (August 1939).
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4. Douglas, C. Gordon, Holdane, J. S., Henderson, Yandell, Schneider, Edward C.: Philosophical Transactions of the Royal Society of Londan. Series B. V. 203, p. 267 (1913).
5. Proc. Royal Society of London, 93:281 (1922).
6. Augenheister, G., and Lau, E.: Die Naturwiss, 16:281 (1928).
7. Starr, Isaac, *et al.*: The American Journal of Physiology, 58:1 (August 1939).
8 Abramson, E.: Scandinavian Archives of Physiology, 66:191 (1933). (Description of the apparatus obtained from Starr, I. *et al.*2).

pensive apparatus was developed and the ballistocardiograph is gradually becoming available to the clinician as an office equipment. Dock and Taubman[9] use a standard Cambridge "Simpli-trol" pulse recording device, or a button, five centimeters in diameter on a rubber membrane, mounted on a rigid arm, extending vertically from an axle and counterweighted on the other side. The capsule or button is placed against the head of the subject, or against a strip that is placed across his shins. Thus the impulse of the body is transmitted. The recording is made through a photo-electric cell, the terminals of which are connected with the arm leads of an electrocardiogram.

The simplest apparatus† now available is the "Glennite Ballisto" pick-up unit. It was described by Sheen[10] as a simple pick-up unit which is a self generating device. The pick-up is made of barium titanate, commercially known as "Glennite" a ceramic material which exhibits piezo-electric qualities.

Piezo-electricity, commonly called "pressure electricity" is said to have been known as early as 1780. Piezo-electric material, is one which, when it receives a mechanical strain, becomes electrically charged and generates an electrical potential. Rochelle salt crystals have been the main source of piezo-electric material used in medical equipment to convert mechanical motion into electrical potential. These crystals are unstable in changing humidity and temperatures, and deteriorate rapidly. A more stable material is therefore necessary. "Glennite" does not change with heat or humidity, and is, under ordinary conditions, practically indestructible. It therefore offers a more reliable element with which to obtain non-varying results.

The Glennite Ballistocardiograph pick-up unit (figure 1) consists of two barium titanate piezo-electric plates A and B, mounted on each side of the metal strip C. The metal strip is held cantilever fashion to the base D. A metal bar E is placed across the bare shins of the subject and the bottom of the cantilever C is placed against the bar with slight pressure.

The up-and-down movements of the heart are imparted to the body and with it to the bar lying across the legs. When the legs of the subject are displaced downward the cantilever is bent in the direction as shown. This puts

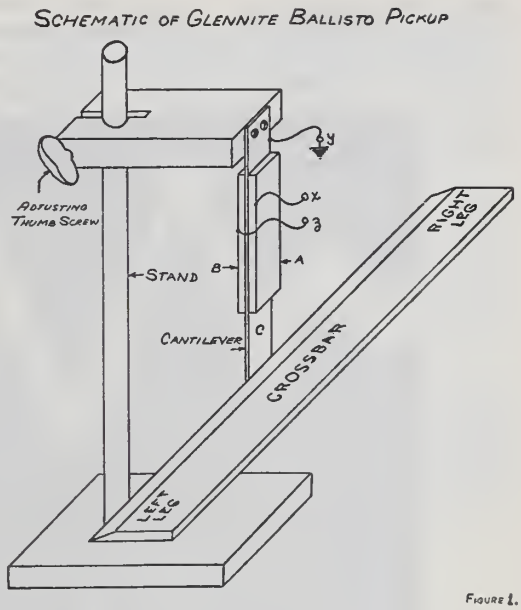

FIGURE 1.

element A in tension and B is put in compression. These elements are so mounted that it causes a positive voltage induced from X to Y and Y to Z. Thus the voltages are additive. Similarly, when the legs have an upward displacement of voltage of the opposite polarity is induced. These voltages are fed into an electrocardiogram through any standard lead and thus recorded.

Whether the instruments are big and costly, or simple and inexpensive as our modern devices are, the significant feature is that all of them produce the same curve in response to these movements of the body. Our curves, correspond in all details to those established by Starr,[7] Brown, Dock[9] and the others. We get something which we call a standard ballistographic curve.

The identifying nomenclature of the ballistocardiographic curve (figure 2) generally used is H, I, J, K, L, et cetera. The physiologic significance and the events in the cardiac cycle with which these pulsations coincide are given the following interpretations.

H-I represents auricular systole. J-K represents ventricular systole. The zenith H coincides with the thrust of the blood against the

9. Dock, William, Taubman, Felix: The American Journal of Medicine, 7:751 (December 1949).
10. Sheen, Thomas N.: In paper read before the New York Academy of Medicine, March 15, 1950.
† Manufactured by the Gulton Manufacturing Company, Metuchen, N. J.

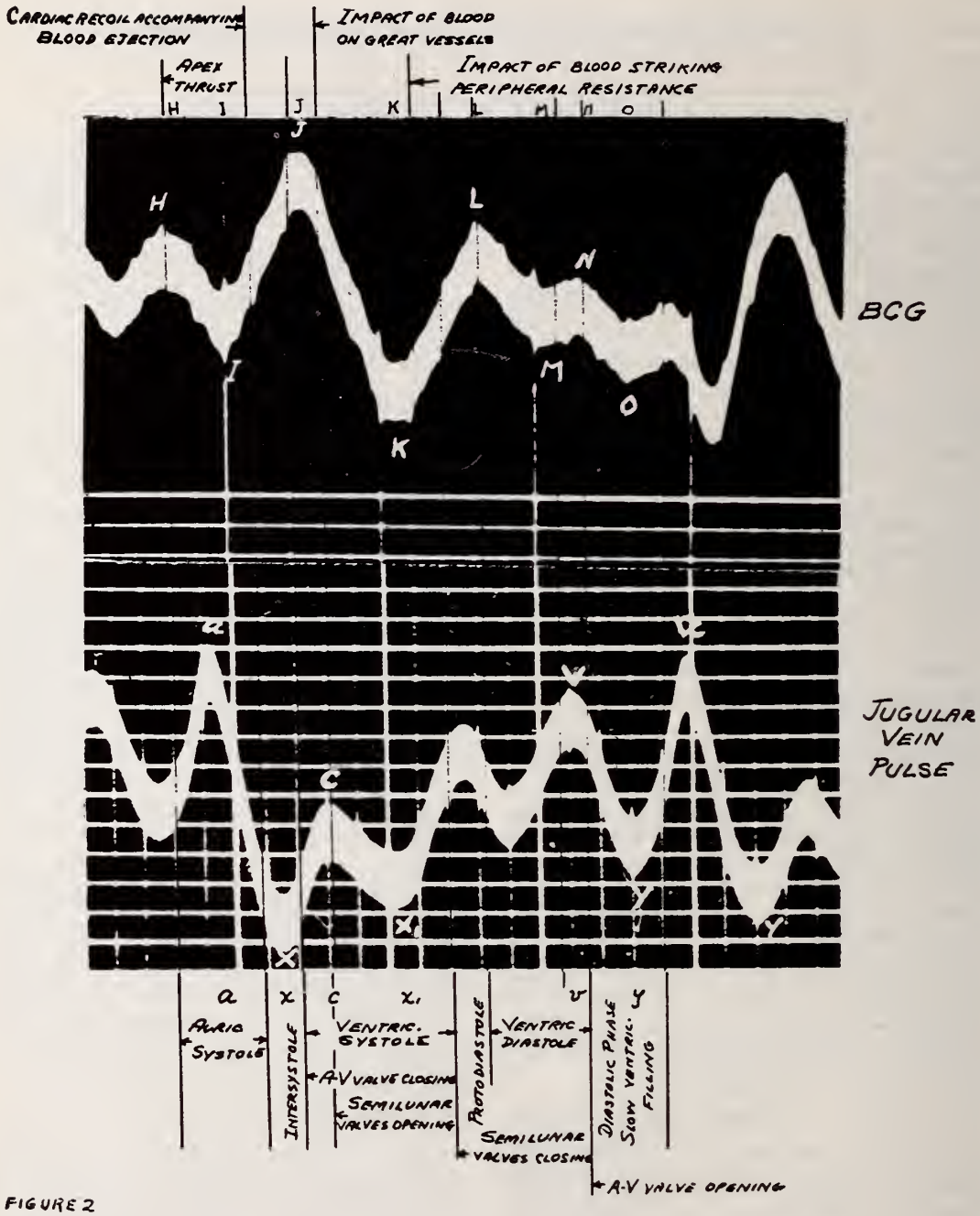

FIGURE 2

apex, and the nadir I with the cardiac recoil accompanying blood ejection. J represents the inpact of the blood on the great vessels and K is the impact when the blood strikes peripheral resistance.

Figure 3 shows the ballistocardiograms of normal hearts. The curves are the same in all essentials, although the ages of the subjects range from 13 to 38. One difference can be noted: the amplitude of the 33 year old subject is considerably lower than the others particularly in the L, M, N, O area. In very old people, the amplitude is markedly smaller. It may be that certain wide age groups, each have specific and characteristic ballistocardiograms —a subject well worth investigating.

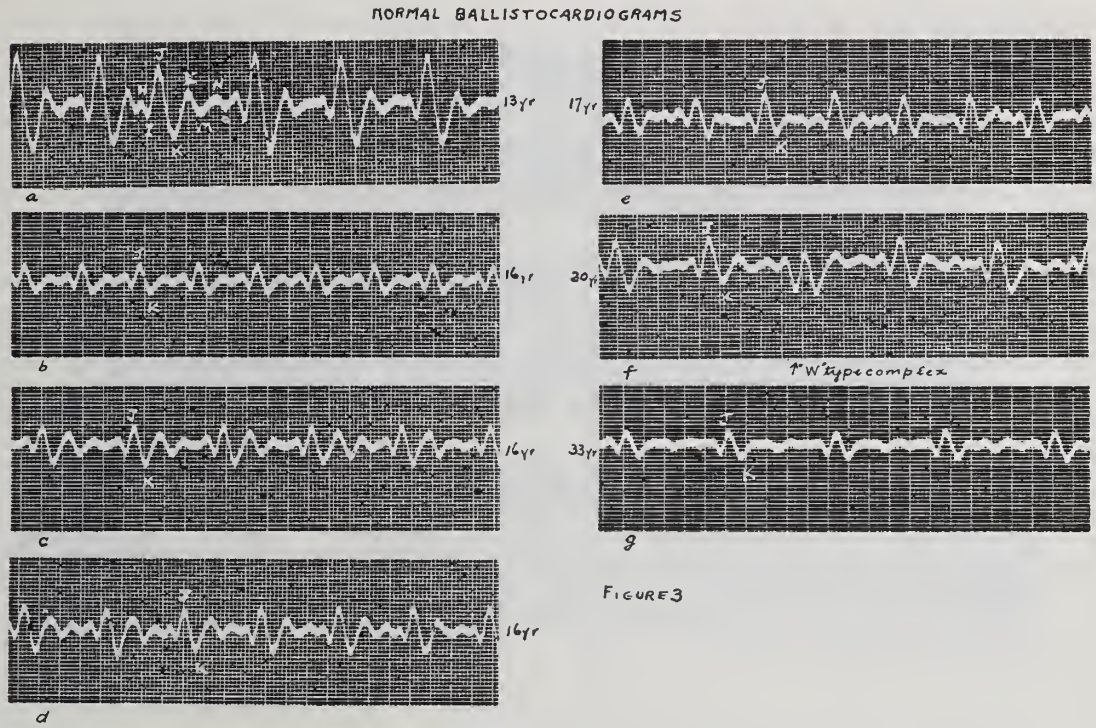

FIGURE 3

Several definite complexes within the ballistocardiographic curve represent abnormalities of the heart when they appear. "Late downstroke", "Late M" (figure 4b) or "Early M" types are described by Starr and his coworkers.[2] A "W" type (figure 3F) appears frequently and portrays cardiac abnormalities. The ballistocardiogram (figure 3F) is a normal graph of a normal young male subject; but here an abnormal complex of "W" type appears. There are two possible interpretations.

1. There are those who think that all ballistocardiograms have artifacts and that the graphs should be judged by the greatest number of characteristic and recurrent complexes. In this case, therefore, the "W" type complex would be an artifact.

2. Some think that these deviations represent the true ballistic motion of the heart. All ballistocardiograms if taken over a long period of time will occasionally show some varying complexes. Apparently the heart action does vary from time to time.

The science of ballistocardiography is rooted in the theory of Newton's third law of motion. "To every action there is an equal and opposite reaction." The curve derived in the ballistocardiogram is interpreted with this in mind: it is the result of a "kick-back", caused by the opposing reaction of the heart against the surging blood within it. The idea occurred to me that the curve represents a direct impulse of the blood itself against the walls of the heart chamber, the opening and closing of the valves, the contraction and relaxation of the muscles and its course through the peripheral vessels. All this movement, *as a pulse,* is imparted to the body and is portrayed directly in a graphic manner by the "ballistic curve".

This thought led to the analysis of the ballistographic curve by relating it to another curve[11] which has already been explored and is well understood, the venous pulse.[12] The phlebogram is a product of the same forces which cause the ballistocardiographic curve. The venous pulse shown in figure 2 was taken with a standard apparatus of the Cambridge "Simpli-trol". The ballistocardiogram was taken with the Glennite "Ballisto" pick-up and recorded through the galvanometer of the

11. Orias, Oscar, Braun-Menendez, Eduardo: The Heart Sounds in Normal and Pathological Conditions. Oxford University Press, London, 1939. Page 43.

12. Groedel, Franz M.: The Venous Pulse and its Graphic Recording. Brooklyn Medical Press, Brooklyn, N. Y., 1946. Page 21.

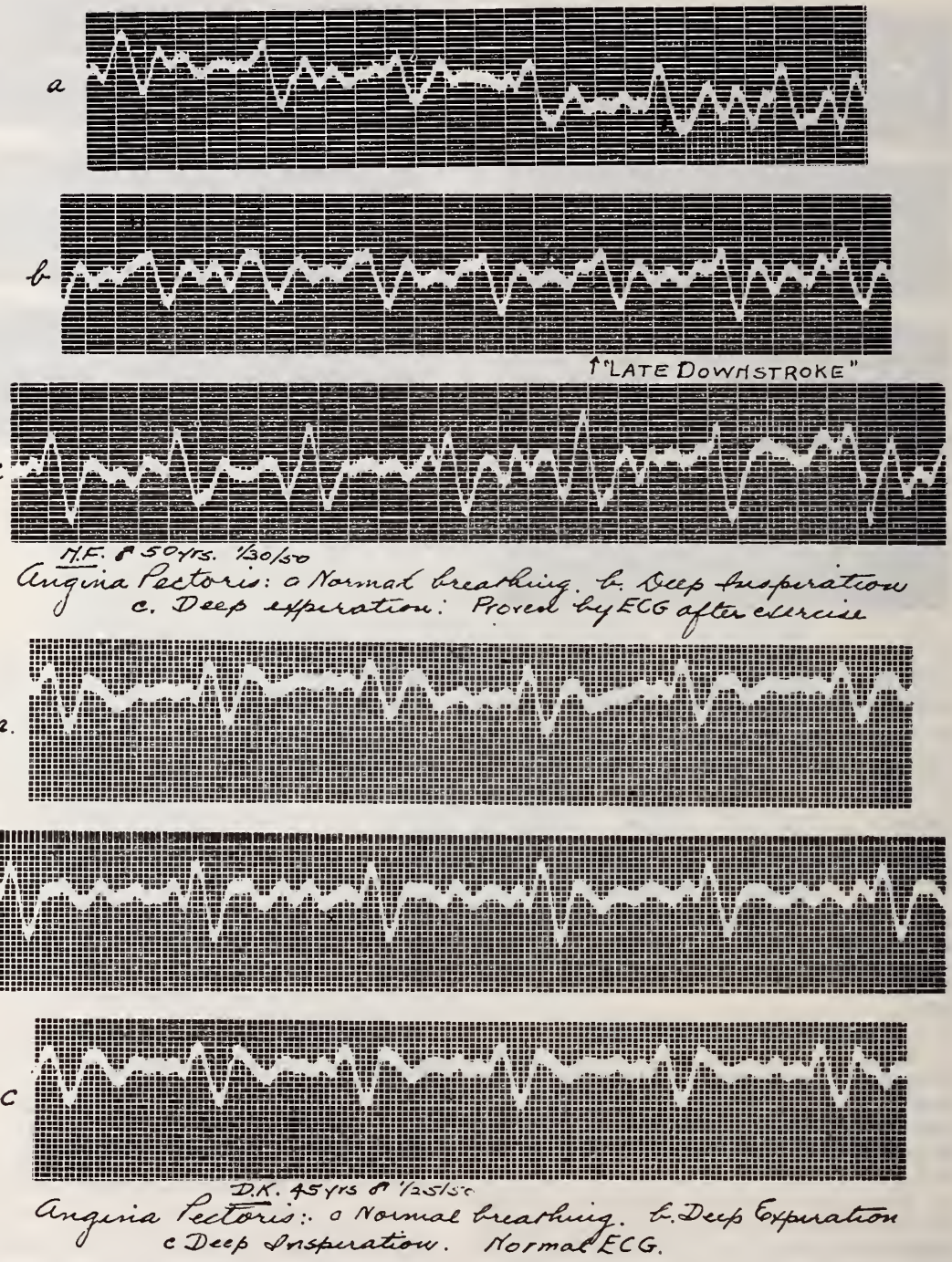

FIGURE 4

same electrocardiogram. The two curves were recorded synchronously. Notice that:

1. *Auricular systole* of the venous pulse, A to X (figure 2) corresponds to the H-I portion of the ballistocardiogram. The curve is downward. Blood rushes to the apex of the heart, through the auriculo-ventricular valves, pushing the heart downward and the body with it. This portion of the ballistographic curve is down. As a recoil

action it would have to be in an upward direction.

2. *Ventricular systole* (A). The isometric contraction of ventricular systole, A to C on venous pulse (figure 2) corresponds to the I-J curve. It extends from the time the auriculo-ventricular valves close and the semi-lunar valves open. It is then that the blood strikes up against the large blood vessels. Blood rushes to the aorta and pulmonary arteries *upward*, therefore the curve is up.

(B.) From J to K the ejection phase of the ventricular systole (figure 2) takes place and the semilunar valves close. The impact of blood now is transferred to the peripheral vessels. Blood rushes *down* the descending aorta and into the peripheral vessels, therefore a *downward curve*.

All these curves would be in opposite directions if they represented the "kick-back" of the heart and with it the body. However, they follow the direction of the greatest impact of the blood and in the same direction as the blood. This does not represent an "action and an equal and opposite reaction", but a pulsation or a tidal wave.

3. *Ventricular diastole*. With the closure of the semilunar valves the phase of ventricular diastole starts. The ballistocardiographic curve from here on is not well defined. There is an upswing in the isometric phase of ventricular diastole, and another upswing in the rapid ventricular filling phase, and again a lesser upswing in the slow ventricular filling phase, up to the time when the curve starts again with auricular systole.

CLINICAL USE

Chief clinical use of ballistocardiography so far is the recognition of coarctation of the aorta, angina pectoris, myocardial damage, arteriosclerosis and several other entities. The two cases that follow could *not* be diagnosed with as much assurance without the aid of ballistocardiography.

1. A 51 year old man in October 1949 began to experience substernal tightness and shortness of breath on moderate exertion which disappeared on rest. Nitroglycerine relieved his distress. He was a well developed man of good stature who appeared younger than his chronologic age. There was no sign of dyspnea or cyanosis. Ocular fundi showed arterial thickening. The heart sounds were normal and there were no murmurs. The heart was not enlarged. The rhythm was regular sinus, 86 per minute. Blood pressure was 130/78. The lungs were clear.

The electrocardiogram was normal. The unipolar leads showed a vertical position of the heart. The present record did not show any changes from several previous records made since 1939. The patient was then subjected to a two step exercise test but there was no change in the electrocardiographic record.

On January 30, 1950, a ballistocardiogram was taken (figure 4, N.F.) showing a definitely abnormal curve. The "late" downstroke is a characteristic of angina pectoris or coronary artery disease. On February 4, 1950, electrocardiograms before and after exercise were again taken, this time by Dr. Simon Dack of Mt. Sinai Hospital, and after exercise there was a marked RST depression in all leads, which lasted for at least five minutes. In this case, *positive findings of angina pectoris predated the findings by the electrocardiogram.*

2. A 45 year old man was awakened from his sleep on January 23, 1950, with a tightness across the chest and pain in the precordial region, radiating to the throat. He felt as if he were choking. He broke out in a cold sweat and felt a sense of anxiety. The pain lasted ten minutes and after taking two aspirins he was able to go to sleep.

For the next two days he felt weak, and had soreness in the left side of his chest. On the third day he had a pain in the left side of his chest and it radiated down his left arm. Two months prior to this attack, he felt tired in the evening, and occasionally had pain around his left nipple. Eleven years ago he had had pain in the right side and dysuria. After several days, he passed two stones in his urine. Since that time, he had frequent right flank pains, and burning on urination. His right side is always sensitive.

He is a well developed man of 146 pounds. His heart was slightly enlarged to percussion, but otherwise normal. Tone was good. Blood pressure was 140/90. He was not dyspneic nor cyanotic. Under the fluoroscope, his left ventricle was slightly predominent. There was a positive Murphy sign on the right side.

Electrocardiograms showed a normal tracing before exercise, and no change after exercise. The ballistocardiograph showed a typical angina pectoris pattern (figure 4 D.K.)

Ten days later, he began to have pains in the right flank and passed some gravel in his urine. During the following ten days he was in the hospital with right kidney colic. He had precordial distress every day. Pyelograms revealed normal kidney function to indigo carmine excretion, and normal kidney and pelvic shadows on x-ray.

The cause for chest pain in his case was difficult to determine. Was it *true angina pectoris* or was the pain *secondary* to kidney colic? The ballistocardiogram made the decision.

SUMMARY

1. Ballistocardiography is among the newest diagnostic methods in medicine. Its progress as an office procedure was impeded by the fact the available apparatus was space consuming, cumbersome and costly. Recently simpler

instruments have been devised. The "Glennite Ballisto" pick-up is the simplest and most recent one, and can be fed into any electrocardiogram for recording.

2. A standard ballistocardiographic curve has been established with known normal and some abnormal complexes. A long run of a normal ballistocardiogram occasionally shows an abnormal complex. Some consider them artifacts. On closer examination, it appears that they represent occasional unevenness of pulsations present in normal hearts.

3. A study of synchronous ballistocardiographs and venous pulse tracings seem to indicate that the so-called ballistic curve is not a "kick-back" action following Newton's third law of motion, but is a pulsation—a "tidal wave" in response to the surging of the blood within the closed cardio-vascular system.

4. Two cases of angina pectoris are presented. In one, the diagnosis made by the ballistocardiogram predates the changes in the electrocardiogram. In the other, it was possible to make the diagnosis with greater assurance than it would have been without ballistocadiography.

29 West Henry Street

A SIMPLIFIED CORD TIE *

Alvin H. Krakower, M.D., and Tamara Nabolotny, M.D., Paterson, N. J.

The conventional tape has been used for the umbilical cord tie at the Barnert Memorial Hospital for many years. There are as many varieties of tying the tape as there are operators using this method. On many occasions the cords were cut through by the tape; on others the tape was tied too loosely leading to subsequent bleeding. Many times, for these reasons, the cords had to be retied.

Recently, Nabolotny introduced to us the use of a small piece of rubber plasma tubing as a means of cord tying. The method is herein described. It is not original with us nor with Nabolotny, but was brought by her from the Displaced Persons Regional Hospital, Aschaffenburg, Germany. It was there that Silesky, a Ukranian physician, first introduced it. The simplicity and effectiveness of the band so impressed the senior author that a series of cases was collected. This is a report of the use of the band in the first one hundred cases.

The simplified cord tie (referred to hereafter as the band) is a piece of used, cleaned rubber plasma tubing. It is 3 to 4 millimeters wide with an aperture of 3 millimeters. A number of bands are cut to the specified width and placed in a 1 to 1000 aqueous solution of zepherin for sterilization. The instruments employed in the use of the band are those normally found in our delivery packs. These include two large hemostats, one Allis clamp, one tissue forceps, and a pair of scissors.

TECHNIC

1. The band is threaded onto an Allis clamp (Fig. 1) prior to delivery.

2. Following the delivery of the baby, the cord is clamped with the first hemostat to a desired length. The cord is milked distal (towards the maternal end) to this and the second hemostat is placed one inch distal to the first (Fig. 2).

3. The cord is cut with the scissors hugging the second hemostat.

4. The Allis clamp previously prepared with the band then grasps the cut end of the cord.

5. One blade of the tissue forceps is placed under the band (Fig. 3) which is then grasped and slipped onto the umbilical cord. Care must be exercised to keep the band under the control of the tissue forceps until it is definitely on the cord.

6. The first hemostat is then removed, and the band is slipped down to a desired length of cord (Fig. 4). Excess cord is then cut.

This report includes 190 consecutive deliveries on the private and ward services of the

* We wish to thank the many doctors who contributed their cases to this work, and to thank the nurses of the obstetrical and nursery services without whose wonderful aid we could not have made this report.

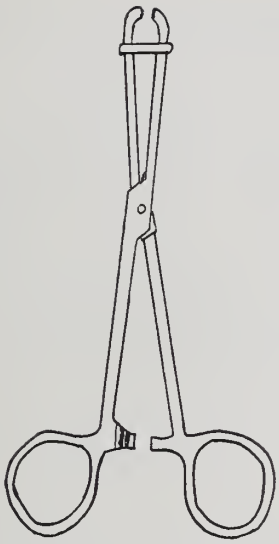

Figure 1.

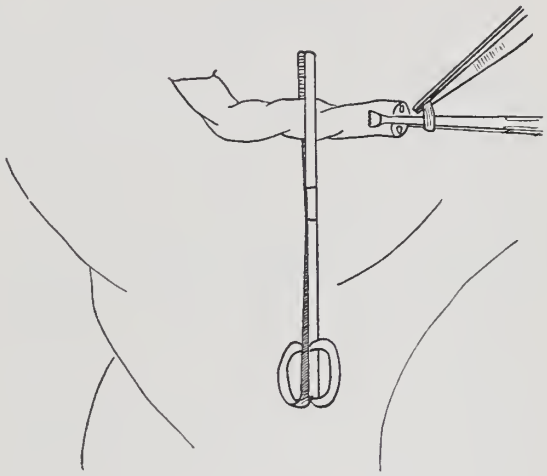

Figure 3.

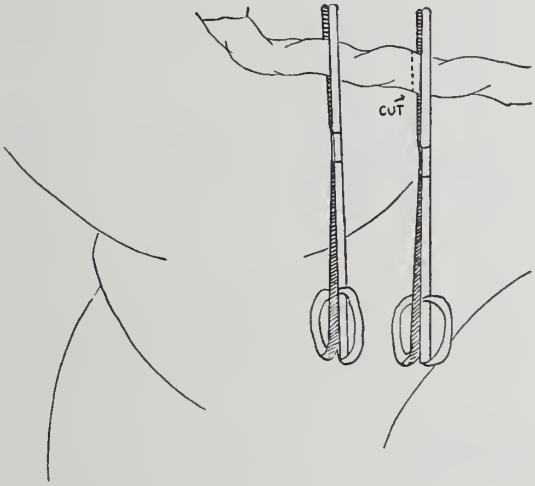

Figure 2.

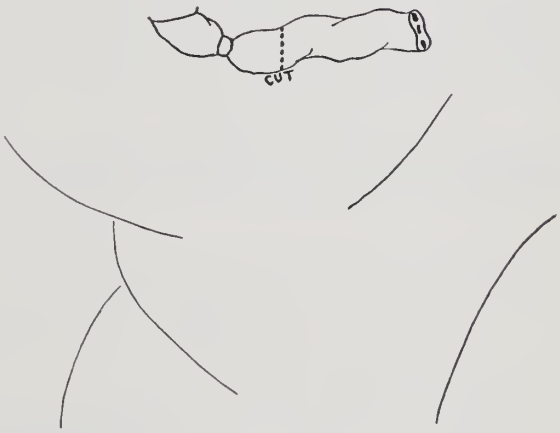

Figure 4.

Barnert Memorial Hospital from December 1, 1949, through January 31, 1950. Of these, 100 cords were tied with the band, and the other 90 were tied with standard umbilical type. Sixteen different operators including obstetricians, general practitioners, residents and interns used the band; a similarly mixed group used the tape. All types of cords from the most attenuated to the very thickest were encountered.

RESULTS

Results were very satisfactory. Of the 100 cords tied with the band, none gave any evidence of bleeding or oozing in the neonatal period. There were four bleeding cords (4.4 per cent) neonatally when the tape was used. Not a single operator tore through the cord using the band; no bands slipped or became loose; no cord needed retying when the band was employed. Nurses reported that the cords tied with the band seemed to "dry up" faster than those tied with the tape. It was not possible for us to learn if the band caused earlier dropping off of the cord because our mothers and babies usually left the hospital by the fifth day. All operators reported greater ease and speed in using the band.

DIFFICULTIES

It was not possible for us to supervise all cases in which the new tie was used. Some difficulties by other operators were encountered in the beginning. These were soon overcome when the technic as outlined was followed closely. The most common mistake was the placement of the two hemostats too close to each other. This did not allow enough room for the Allis clamp to obtain a good grasp on the cord. At least one inch must separate the hemostats to overcome this difficulty. Another error commonly made was the removal of the tissue forceps before the band was completely on the cord. Finally, before bands cut to proper width were given in the sets, some operators were cutting their own bands too wide. It has been found that a width of 3 to 4 millimeters gave the best results. Anything narrower than this tended to tear; and anything wider made it difficult to slip the band onto the cord with ease.

ADVANTAGES

We have found this simple band to have the following advantages over the use of umbilical tape as a cord tie:

1. Speedier, easier application.
2. No cutting of the cord.
3. Wet rubber gloves made more slippery by vernix caseosa and escaping Wharton's Jelly need not be considered.
4. No slipping of the tie after it has been applied.
5. No bleeding or oozing of the umbilical cord neonatally.
6. No need for a retie at any time.
7. No expense. Used, cleaned rubber plasma tubing is employed.

SUMMARY

A simplified, inexpensive method of cord tie has been presented. The technic of its application has been described. Report of 190 consecutive cases is discussed using a piece of rubber plasma tubing on 100 and conventional umbilical tape on the other 90. Because of the advantages presented by this preliminary work, it is felt that further use of this simple band tie is justified.

The authors take this opportunity to thank Mrs. Helen Krakower whose fine drawings were used for making the cuts in this article.

528 E. 29th Street

WE MUST FIGHT ON *

Mrs. David B. Allman, President, Woman's Auxiliary to the American Medical Association

Madam President, Officers, Fellow Auxiliary Members and Guests:

I am truly delighted to be here with my own Auxiliary on this occasion and greet you as your national President and as your fellow member.

From this very hotel, eleven short months ago, you sent me on my way as your leader and as your representative. I trust that I have fulfilled your expectations. I know that during whatever trials or tribulations I may have had I have always reflected in the consolation that here were my friends who would support me in all of my endeavors.

I am therefore proud and most happy at this time officially to bring you not only my warm personal greetings as your president, but those of all your national officers as well, all of whom, I know join with me in wishing my home Auxiliary all possible success.

The position of President of the Woman's Auxiliary to the American Medical Association is rapidly becoming a "man's size job". In the past sixty days I have made official visits to the state meetings in Illinois, Missouri, Tennessee, Georgia, Florida, Texas, Pennsyl-

* Delivered before the Twenty-third Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey, Atlantic City, N. J., May 23, 1950.

vania and Ohio. Between now and my convention in San Francisco next month, I plan to visit North Dakota and Minnesota. During the year I will have visited practically every state in the union that has an organized Auxiliary, and will have traveled fifty thousand miles, which in itself, is no small undertaking for one year.

It has been a most pleasant experience, however, and I can never thank you of New Jersey enough for the loyal support you have always given me. I have met many wonderful women during the past year. I have visited many Auxiliaries larger than ours, but I have found no better Auxiliaries, nor any finer women, than we have right here in our own New Jersey.

This will go down as an historic year for the Woman's Auxiliary to the American Medical Association. It has been a crucial year and one in which our Auxiliary has very definitely proven its worth, not only to our parent organization, but to the American Public as well.

If the people of this nation are fully to recognize and clearly to understand the grave issue involved in the proposal for a government controlled system of medicine, then all of us who know the facts have an obligation to speak out for the matter seriously concerns the health and welfare of every American.

That our Auxiliary members are responding in a most magnificent manner is attested to by the statement of Dr. Elmer L. Henderson, the President-Elect of the American Medical Association, wherein he states, "By their splendid efforts in this important work our Woman's Auxiliaries throughout the country are earning new gratitude and new appreciation from their medical societies. They are gearing their activities smoothly into local campaigns and the result is a well coordinated informative program to carry the truth to the public."

We of the Auxiliaries have built a public relationship during the past year, the benefits of which will be felt by American medicine for many years to come.

We have done much during the past year to stem the tide of compulsory health insurance, but we would be foolish indeed to assume that final victory had been won. *We must fight on!*

American medicine is stronger today than at any time in its history, due, in a large measure, to the staunch support of our Auxiliaries. We have won a new measure of public confidence because we have fought for our convictions.

And we of the Auxiliaries are particularly qualified to carry this torch for American medicine because of the facts as so aptly expressed by the President of the American Medical Association, Dr. Ernest E. Irons, in his statement that "Women's knowledge of family health problems, women's insight into great public issues that closely concern family welfare and women's enormous ability to organize their tasks and complete them are three of the greatest assets that American medicine and its friends have in the campaign against government controlled medicine."

By your splendid work here in New Jersey you have merited for the Auxiliary the great confidence that American medicine has placed in us.

As your national President I am proud of the grand work that my home state has done and is continuing to do individually and collectively as an Auxiliary.

The tide of battle has turned in our favor. We are going forward. We are now on the offensive and we must maintain that offensive until the final battle is won. *We must fight on!*

Let us reach our objectives in 1950 and be proud of our opportunity to carry the banner for American medicine and the *American way of life.*

I thank you.

104 St. Charles Place

STATE ACTIVITIES

PARATHION POISONING

In a semi-agricultural state like New Jersey, insecticides are widely used. Attention is called to parathion, a highly effective pesticide which, unfortunately, can be toxic to man too. Physicians in suburban and rural areas may be called on to recognize and treat cases of poisoning with parathion. The drug is a cholinesterase inhibitor, known variously as parathion, E-605, TEPP, ethyl tetraphosphate and nitrophenyl thiophosphate. It is used by florists and farmers, and it may be that it will become popular this fall in the spraying of home gardens.

The systemic effects of parathion are similar to those of other cholinesterase inhibitors, and to the effects of the acetylcholine analogues (pilocarpine, muscarine, arecoline, mecholyl, doryl). Effects include giddiness, headache, nausea, vomiting, abdominal cramps, diarrhea, miosis, sweating, salivation, lachrymation, confusion, weakness and muscular fasciculations. A sense of tightness is felt in the chest. Fatalities appear to result from constriction and secretions in the bronchi or arrest of the heart. On the other hand recovery from the acute poisoning is usually complete and uneventful. There has been no evidence of permanent injury in such cases.

Treatment may be effective if atropine grains 1/100 to 1/50 (0.65 to 1.3 milligrams) are given at once and every hour or oftener as needed to keep the patient fully atropinized (mouth dry, pupils dilated). If the lungs have filled before the atropine takes affect, clear the bronchi by postural drainage. Oxygen is then indicated. Morphine is contra-indicated. Muscular fatigue and weakness may reach a degree requiring artificial respiration. Following even mild symptoms no additional exposure to parathion or other phosphate esters should be allowed until time for cholinesterase regeneration has been allowed.

Intoxication by parathion or other cholinesterase inhibitors is an acute episode of 24 to 48 hours. It is terminated by cholinesterase regeneration and is followed by period of gradually decreasing susceptibility to small exposures. Successive parathion exposures may deplete cholinesterase reserves progressively and create a susceptibility to small doses of tetra-ethyl pyrophosphate or vice versa. Since cholinesterase is regenerated rather slowly in man, patients who have suffered parathion poisoning should not be permitted to experience further possible exposures to this compound until it has been established that cholinesterase blood levels have returned to normal. Parathion and other phosphate insecticides are not locally irritating, but they produce local cholinergic effects. There has been no chronic or cumulative action other than that on cholinesterase as described. It remains to be seen whether dangerous residues can be detected on food crops sprayed before harvest.

TROPICAL DISEASE ABSTRACTS

By Committee on Tropical Diseases

Christian Segard, M.D., Chairman

Two recent papers from the Veterans Administration should be evaluated by every physician treating veterans. They appeared in American Journal of Tropical Medicine (29:443-451, 1949) and in the Kansas Medical Society Journal (51:49, 1950). Both papers indicate that the veteran's difficulty is to obtain accurate diagnosis and treatment of certain tropical infections. This is due to lack of facilities in the laboratory and failure to recognize tropical parasites.

The report shows that amebiasis was present in 40 per cent of a group of patients whose stools were critically examined and that other protozoa and helminths comprised an additional 20 per cent.

On the question of amebiasis, the committee brings to the attention of physicians the editorial in the February 4 (1950) Journal of the American Medical Association. The problem is discussed at length. It is generally agreed that where there is liver involvement in amebiasis, no other drug is equal to emetine. Some physicians believe all patients should receive emetine initially. A second course of treatment should not be given too soon, perhaps not before three weeks or a month.

SYMPOSIUM ON MENTAL DEFICIENCY

For the first time in New Jersey's history, psychiatrists, psychologists, social workers, pediatricians, educators, lawyers and parents will meet on October 28 at a statewide conference to discuss the manifold problems connected with mental deficiency. Sessions will be held in the huge gymnasium at Rutgers University, New Brunswick, under the sponsorship of three state departments, three professional societies, and the New Jersey Parents Group for Retarded Children, Inc. This program will coincide with the initial studies to be undertaken by the Joint Legislative Commission to study Mental Deficiency in New Jersey.

Every professional worker and parent concerned with this problem is cordially invited to attend. It is estimated that there are 50,000 persons in New Jersey who may be classified as mentally deficient. The social and economic waste inherent in these statistics has never been computed or analyzed. This meeting is intended as a foundation not only for a comprehensive understanding of the nature and implications of mental retardation, but also for a systematic study of causes and scientific treatment.

Among some of the general topics to be discussed will be: "The Historical and Present Day Picture of Mental Deficiency"; "Medical Problems in the field of Mental Deficiency"; "Psychological, Educational and Social Problems of Mental Deficiency".

Panel discussions later in the day, of especial interest to the medical profession, will include such subjects as "Physical Causes and Medical Treatment in Mental Deficiency"; "Mental Deficiency in the Young Child as Seen by the Pediatricians"; "Diseases Simulating Mental Deficiency"; "Medical Unknowns in Mental Deficiency"; "The Values of Certain Special Medical Treatment"; and "Revascularization of the Brain in Children with Mental Deficiency, Convulsive Disorders and Spasticity".

Papers will be given by outstanding authorities in each field.

The conference will start with registration at the Rutgers Gymnasium at 9:30 a. m. A prominent public figure will address the luncheon meeting in the college cafeteria, and general and professional meetings will take place through the afternoon.

The other sponsors of the conference are the New Jersey Department of Health, New Jersey Department of Education, New Jersey Psychological Association, New Jersey Neuro-Psychiatric Association and the New Jersey Education Association.

For further information write to Howard Smith, Chairman, Statewide Conference on Mental Deficiency, 154 Davey Street, Bloomfield, New Jersey.

SPECIAL COURSES IN INTERNAL MEDICINE

A symposium in internal medicine, fashioned to meet the needs of the practicing physician, will be given at New York Mt. Sinai Hospital from October 16 to December 16, 1950; and repeated during the period beginning January 22, 1951. The full course runs from 9 a. m. to 4:30 p. m. weekdays, and Saturdays from 9 a. m. to 12 noon. Separate courses, however, may be taken. The following subjects are available:

Cardiovascular diseases, kidney diseases, gastro-intestinal disorders, endocrine disorders, diseases of the liver, diseases of the chest, disorders of metabolism, hematology, dermatology, allergy and venereal diseases. Each separate course is given for one half day a week, so that a practitioner who cannot devote full time to the program, can register for one or more half days a week and get intensive graduate training in one or more fields.

For further information, write to: Registrar for Medical Instruction, Mt. Sinai Hospital, 2 East 100th Street, New York 29, N. Y.

COURSE IN SURGICAL SPECIALTIES

Intensive courses in certain surgical specialties are announced for the September 25 to December 15 period at Mt. Sinai Hospital, New York. Available will be courses in ophthalmology, otolaryngology, gastro-intestinal surgery and gynecology. For details, write to: Registrar for Medical Instruction, Mt. Sinai Hospital, 2 East 100 Street, New York City 29.

CEREBRAL PALSY MANUAL

Publication of *A Manual of Cerebral Palsy Equipment* has been announced by Zeta Tau Alpha, a national college sorority. This manual, sponsored by the sorority, is published by the National Society for Crippled Children and Adults. It contains photographs, information regarding use, working diagrams for construction, specifications, materials and directions for making 127 items of equipment and aids. It is distributed through the National Society to physicians and professional personnel at a price of $3.00.

The manual was undertaken because of the great need of the cerebral palsied for special equipment. Knowledge and facilities for treating cerebral palsy victims have only been developed in recent years, and much of the equipment has been invented or improvised by physicians and other professional personnel.

The National Society for Crippled Children and Adults was selected to gather and edit the material for this manual because the nationwide scope of its cerebral palsy program makes it the outstanding agency in this field.

The manual was compiled with the guidance of the American Academy for Cerebral Palsy, professional organization of medical specialists in this field. Many other professional groups, agencies, hospitals, treatment centers and schools cooperated in submitting material.

The manual is available through the National Society for Crippled Children and Adults, 11 South La-Salle St., Chicago 3, Illinois.

AMPUTEE MANUAL

A fifty-four page, profusely illustrated training manual for the double-above-elbow amputee is now available from the Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, New Jersey, at a cost of one dollar per copy. *The High Double Arm Amputee* was written by John B. Seeley, a double arm amputee who is a consultant in amputee training to the Kessler Institute. The booklet is of practical service to the arm amputee, and also provides a guide to professional rehabilitation personnel whose work brings them into contact with this type of handicap.

The booklet describes and illustrates methods with which the arm amputee can meet his personal, family, social, and business responsibilities. In addition, there is a section on general instructions, care of the artificial arm, sports and recreation, and travel. The technics for dressing, grooming and eating with and without artificial arms are presented in considerable detail. The manual is introduced by Dr. Henry H. Kessler.

The author of *The High Double Arm Amputee* uses a cineplastic prosthesis, but his instructions are applicable to any type of artificial arm, and are of service to the single as well as the double arm amputee. The manual is obtained by sending a request together with a dollar remittance to the Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J.

MEMO TO BELLEVUE ALUMNI

Dr. Luther MacKenzie, senior member of the faculty of New York University College of Medicine will be the guest of honor at an Alumni Association dinner to be held Thursday evening, November 30, at the Waldorf-Astoria. Professor MacKenzie will be affectionately remembered by all N. Y. U. medical alumni from the class of 1908 to the class of 1950. No Bellevue alumnus will want to miss this chance to pay his respects to one of the grand old men of American medical education; nor to pass up the opportunity to meet once more many of his old classmates. Even the Waldorf-Astoria will not be big enough to accommodate all who want to be counted in on this one. So write promptly for tickets and further details. Address: General Alumni Headquarters, College of Medicine, 100 Washington Square, New York 3, N. Y.

INTERNATIONAL COLLEGE OF SURGEONS

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Convocation in Cleveland, Ohio, October 31, November 1, 2, 3, 1950.

The program will include scientific sessions on general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery. In addition, an extensive technical and scientific exhibit will be presented by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals and others. Special entertainment for the doctors' ladies has been planned.

All doctors interested in surgery are invited to attend, and can obtain a program on request to Arnold S. Jackson, M.D., 1901 Adams Street, Madison 5, Wisconsin. For hotel reservations, write to Committee on Hotels, International College of Surgeons, 511 Terminal Bldg., Cleveland 13, Ohio.

OBITUARIES

DR. ISAAC L. GORDON

Dr. Isaac L. Gordon, widely-known Jersey City physician, died suddenly on June 30, 1950, while vacationing at Salt Lake City, Utah.

Dr. Gordon was born in New York City in 1893, spent his early years in Maine and received his medical degree from Bowdoin College, Maine, in 1916. Following graduation he enlisted in the Royal Canadian Army and transferred to the United States Army the following year. He had been associated with the Greenville Hospital since 1922. He was a director of the Hebrew Home for the Orphans and the Aged and of the Jersey City Jewish Community Center.

DR. WILLIAM E. McCORKLE

Dr. William E. McCorkle, who was serving his third term as Hunterdon County physician, died at his home in Ringoes on June 21, 1950, at the age of 48.

Dr. McCorkle was a graduate of Hahnemann Medical College, Philadelphia, and had practiced medicine in Ringoes for 22 years. He served as coroner from November 1936 to January 1942 and was active in civic affairs.

DR. STEPHEN SANTANGELO

Dr. Stephen Santangelo, prominent Jersey City surgeon, died suddenly at his home on June 7, 1950.

Dr. Santangelo was born in New York in 1899. He was graduated from Temple University School of Medicine in 1922 and served internship in local hospitals. He was resident surgeon at Jersey City Medical Center and served on the staffs of other institutions throughout the county.

DR. JOHN E. L. VAN SCIVER

Dr. John E. L. Van Sciver, retired physician, died on June 16, 1950, at Cooper Hospital, Camden, at the age of 78.

Dr. Van Sciver, who lived in Haddonfield, retired four years ago after practicing for more than 50 years. He was a graduate of Jefferson Medical College and was an emeritus member of the Camden County Medical Society and The Medical Society of New Jersey.

COUNTY SOCIETY REPORT

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

With the president, Dr. Lloyd Hamilton, in the chair, the *Hunterdon County Medical Society* held its midsummer dinner meeting at the Union Hotel in Flemington on July 25. A motion was passed authorizing the secretary, Dr. John Fuhrmann to draft a resolution pledging the society's full support for the rapidly developing medical center project. Dr. Ray Trussell, the recently appointed medical director of the new center spoke briefly on the need for a community health council. Report was made of the untimely death of the county physician, Dr. William McCorkle who had been a member of the Hunterdon County Society since 1928. The secretary was instructed to draft an appropriate resolution of condolence and forward it to Mrs. McCorkle. Dr. Hamilton then introduced the guest speaker of the evening, Dr. Harrold Murray, vice-president of The Medical Society of New Jersey who gave a lively account of the activities of the New Jersey delegation at the A.M.A. convention in San Francisco last month. Dr. Murray also discussed the need for community health councils in our state, and he gave a brief report on growing plans for the medical phases of civilian defense in New Jersey.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

POWERFUL GROUPS ASK BETTER LOCAL HEALTH ADMINISTRATION

Recognition of the principle of home rule, necessity for fewer, better, and larger local health units, and problems of financing received the greatest emphasis in the public hearing on local health administration held in the State House on June 29.

The hearing was called by the Governor's Committee on Local Health Administration to sound out public sentiment before a subcommittee began drafting a bill to be submitted to the Legislature. Mrs. Gloanna Wallace MacCarthy, of Maplewood, former Assemblywoman from Essex County and chairman of the Committee, presided.

The position of The Medical Society of New Jersey was presented by Dr. C. Byron Blaisdell chairman of the society's Subcommittee on Legislation. Among the points made by Dr. Blaisdell were these:

"The Medical Society of New Jersey has long been on record in favor of the main purpose for which this Committee has been appointed by the Governor. In its most recent formal expression, the House of Delegates of The Medical Society of New Jersey on April 26, 1949, declared by resolution that:

> 'The first requisite of any effort to improve local health services in New Jersey is the enactment of legislation to enable existing local health jurisdictions to consolidate their resources and populations into regional units of sufficient size to support a minimum, full-time, professional, health department staff.'

"It is a basic requisite in the creation of better local health departments that any consolidated health district should cover a population of not less than 25,000 persons and preferably 50,000 or more. Only thus can we hope to have satisfactory standards of financial support for the personnel and activities of such a health department.

"A full-time health officer in charge of such a department should be either a doctor of medicine who has had public health training or extensive experience in public health work, or a doctor of public health, or a health officer licensed by the State who has had at least five years' experience as administrator of a local health department of 25,000 persons or more.

"The Medical Society of New Jersey is entirely sympathetic to the principle of home rule in local autonomy. Nevertheless, we feel that some requirement for formal study and action on the question of consolidation of local health jurisdiction must be incorporated in the statute if we are to hope for reasonably early action at the local level to create the better local health services that this legislation is designed to create."

The advantages of county health departments were cited by John Hall, executive secretary of the New Jersey Health and Sanitary Association. He said:

"Health departments on a county basis would have many advantages such as facility of organization, wide coverage of sizeable populations, simplicity of money raising, and easy coordination with other groups interested in health and already operating within county lines. Many of us hope that an acceptable bill can be drawn which will leave the door open so that the county pattern of new health units can be adopted."

The Public Health Council of the State Department of Health in its brief said that "fewer, larger, local public health units can best serve the interest of the citizenry if set up on a basis not necessarily following county lines".

Several groups urged that the committee give some consideration to legislation proposed in Washington so that New Jersey might be able to benefit from any federal financial grants which might become available.

Groups which submitted statements included the New Jersey State Nurses Association, the State Organization for Public Health Nursing, the League of Women Voters of New Jersey, the State League of Municipalities, the New Jersey Division of the American Association of University Women, the New Jersey Health Officers Association, the New Jersey Hospital Association, the New Jersey Tuberculosis Association, the Cape May County Health Department, the New Jersey Association of Township Committeemen, and the State Dental Society.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. R. John Cottone

This, my first message to you through The Journal, brings to each Auxiliary member my sincere wish that you have enjoyed a pleasant summer and are now looking forward, with enthusiasm, to another busy and productive year.

Increased membership will be a keynote for our coming year's work. Somewhere in this state of ours there are 3500 eligible women, each of whom is needed as an Auxiliary member. Let us all join together in an intensive membership campaign to gather in these nonmembers. We will all be proud and happy to see our State Auxiliary growing, steadily, in number and in strength as an organization.

Also, I urge all county presidents to strengthen the relationship between your group and the medical society in your county, for here lies the real strength in our entire field of public relations. If we are always available for service to the medical society when needed and respond readily to their call, we will have gone a long way in making the alliance stronger.

CASE REPORT OF THE BULLETIN

History—The Bulletin of the Woman's Auxiliary to the American Medical Association is published quarterly to keep its members abreast with the news vital to the organization. Here in New Jersey, there has been a negligent attitude regarding this splendid, informative publication.

Physical Signs—Marked inertia on the part of our members. Our average of subscribers is much less than the low national ten per cent ratio.

Symptoms—Woeful lack of interest in this important source of information.

Treatment—Prompt subscription to the Bulletin.

Prognosis—Excellent for enlightenment. If the Bulletin is read, our New Jersey Auxiliary will be better informed and more efficient.

Mrs. Chester I. Ulmer,
Bulletin Chairman.

BOOK REVIEWS

An Atlas of the Blood and Bone Marrow. By R. Philip Custer, M.D. Pp. 321. Philadelphia, W. B. Saunders Co., 1949. ($15.00)

This atlas of hematology is well-documented with illustrations and photomicrographs of the normal and abnormal constituents of the blood and bone marrow. It is so presented and written that the fundamentals of the normal and pathologic physiology of blood formation and destruction become easily understandable.

One section covers the development and normal function of hematopoetic tissues and the author correlates the changes in the peripheral blood with those in the bone marrow of the various diseases of the blood-forming organs. Many clinical features with reference to laboratory aids interspersed with clinical notes help to make this text a valuable adjunct to the physician's library.

Nathan Zukerberg, M.D.

Haemoglobin; a Symposium Based on a Conference held at Cambridge in June 1948, in memory of Sir Joseph Barcroft. Edited by F. J. W. Roughton and J. C. Kendrew. Pp. 317. New York, Interscience Publishers, Inc., 1949. ($8.50)

The status of hemoglobin, its chemistry, reactions, electronic structure and kinetics, its analyses and physico-chemical reactions, are given in a scholarly manner. The section on the biochemistry is particularly well-written. The entire subject is

covered in eight separate sections under various headings, each further subdivided in from four to six papers. Of great interest is the section on "Differences between adult and fetal hemoglobin," particularly the paper by Dr. J. H. Jonxis of Rotterdam entitled "Fetal Hemoglobin and Rh Antagonisms". The latter advances the theory that the component parts of the fetal hemoglobin molecule are more firmly connected than the adult molecule. In erythroblastosis fetalis, it is the cells containing this fetal hemoglobin which are hemolysed more readily. Another paper in this group goes more deeply into the crystallization and solubility patterns.

This work represents an excellent tribute to a great physiologist by his admirers. The papers are so technical that it makes this volume difficult to read as a text. However, as a source of information about hemoglobin, this is an extraordinary reference.

M. W. Shulman, M.D.

Quinidine in Disorders of the Heart. By Harry Gold, M.D. Pp. 115. New York, Paul B. Hoeber, Inc., 1950. ($2.00)

Twenty-five years ago the action and use of quinidine were only vaguely understood. In this concise manual, Dr. Gold strips the mystery from the drug and tells how to obtain maximum therapeutic benefits from its use in cardiac arrhythmias. The author states categorically that disorders of cardiac rhythm constitute the *only* indication for the use of quinidine in disturbances of the heart. Other chapters concisely discuss therapeutic and toxic actions, absorption, elimination, tolerance and dosage. There is a study of disorders of rhythm including a review of the physiologic mechanism involved, the therapeutic objective to be attained, the dangers encountered and the course of treatment indicated.

The chapter on the combined use of quinidine and digitalis deserves particular praise for its lucid and comforting advice. This monograph is recommended heartily as a 'practical manual for all those who treat heart disease'.

Edward C. Klein, Jr., M.D.

Psychiatric Sections in General Hospitals. By Paul Haun, M.D. Pp. 80. New York, Architectural Record, 1950. ($4.00)

The increasing need for psychiatric sections in a general hospital; the acceptance of such a need; and the realization that a hospital cannot adequately serve the community without a psychiatric section; all combine to make this medically oriented book on "Hospital Architecture" required reading for the modern hospital administrator.

Dr. Haun, is a psychiatrist with many years in this specialty. He has also had vast experience in the hospital building program as Chief of the Hospital Construction Unit of the Department of Medicine and Surgery of the Veterans Administration.

While this book is primarily designed for the use of architects, its method of presentation, its bibliography, its numerous examples of psychiatric sections and constructive criticism thereof, all make it equally valid to the hospital administrator. The analysis of psychiatric sections provide us with the experience of others without having to live through these painful periods ourselves. Dr. Haun offers us an outline which provides a guide for the construction of the hospital and gives cogent information on size and cost estimating.

The section on "The Psychiatric Floor Incorporated in a General Hospital" by Charles Butler and Addison Erdman is a plan for a 24-bed psychiatric floor in a hypothetical 200-bed general hospital. This section reveals many methods by which floor space, personnel utilization, and patient care can be expanded without a corresponding increase in cost.

This book fills a great need both in architecture and psychiatry. It outlines methods by which psychiatric sections can meet the medical needs of the patient. It develops a procedure by which the structure of the hospital can be made to serve the needs of the mentally ill patient in the community rather than the needs of the patient being forced into an architecturally sound but medically inefficient envelope.

If there is one adverse criticism that can be made it is that there is much too little of this book.

C. N. Baganz, M.D.

Medical Gynecology. By James C. Janney, M.D. 2d ed. Pp. 454 with 108 figures. W. B. Saunders Co., 1950, Philadelphia. ($6.50)

This book has two unusual and important features: first, it does not describe the diseases according to the changes in the different organs and a discussion on the symptomatology and treatment. It approaches the subject from the direction of the patient's complaints. It stresses the importance of the history and gives valuable advice on taking it correctly. The complaints of the patient are arranged under headings which list the physical and pathological causes for each complaint. Then diagnosis is discussed and the interpretation of tests and examinations is added so that the treatment can be the subject of description and evaluation. This is an unusual approach but it has many appealing points. It seems doubtful whether this can be used as the sole method of teaching, but as an addendum to the conventional methods, it is not only interesting but didactically valuable.

Second, the chapter on "socio-medical problems in gynecology" is a gem. The frank discussion of emotional, economic and social factors, of contraception, preparation for marriage, marital maladjustments: All of these should be treated in modern textbooks. These topics are handled with experience, responsibility and delicacy; the author's discussion cannot be praised too highly. Even if one does not agree with some of the author's views for instance, premarital self-preparation of a virgin for coitus, one still feels and admits that an important contribution has been made to the literature with this volume. Students, practitioners and specialists can profit from Dr. Janney's title on medical gynecology.

Ben Liegner, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **September, 1950** **No. 9**

AN adequate diet is universally accepted as one of the protective measures against infection by the tubercle bacillus and as an essential factor in treatment. In infections caused by other organisms, however, the relationship between resistance and good food is not clear cut and much careful research remains to be done.

NUTRITION AND INFECTION

Every mother of a family, and every doctor in practice, firmly believes that the best bulwark against infection is good wholesome food. The association of tuberculosis with poverty and malnutrition is particularly noteworthy. In the late war the countries with the highest incidence of tuberculosis were those that suffered the greatest privations and food shortages. But, other factors besides nutrition may well have been involved. The poorly fed community often suffers from fatigue, low morale, anxiety, overcrowding, and poor hygiene, and its hospital and public health organizations are likely to be defective. Moreover, in spite of the appallingly low nutritional standards in Germany at the end of the war, there were no major epidemics. Then again, children brought up in apparently admirable living and dietary conditions still contact measles, chickenpox, mumps, and poliomyelitis, and well-fed adults catch colds and influenza. Poliomyelitis, indeed, seems to have a predilection for young adults in excellent physical condition; and the incidence appears to be much higher in well-fed countries like the United States than in, for example, the ill-nourished African. Most bacteriologists, therefore, hesitate to accept the view that malnutrition increases susceptibility to infection.

The influence of heredity, both in the host and in the infecting organism, cannot be overlooked. Webster, by inbreeding and selecting from a common stock of mice, bred two strains, one of which was almost completely immune to a given infective dose of *Salmonella enteritidis*, the other suffered almost a 100% mortality. Such inbreeding and selection, however, did not produce resistance to other organisms.

If nutrition plays a part in the resistance to infection, one would expect antibody production to be affected, particularly as antibodies are derived from the serum proteins, which are lowered in frank malnutrition. At the end of the war Gell had an exceptional opportunity for studying the relation between protein deficiency and antibody response in patients and prisoners from the Ruhr suffering from malnutrition—they were on a diet of only 1000 calories daily. Their antibody response, as measured by agglutination tests, was determined before and after infection with a rather bizarre mixture of tobacco mosaic virus and avian red cells, chosen because there could not be preformed latent immunity to them. British troops served as controls. The results showed that the well-nourished British soldier had a better antibody response than the half-starved Germans, but the differences, though statistically significant, were not as great as might be anticipated. Gell concluded that "under-nutrition does not play as large a part in widespread epidemics as is generally supposed."

Vitamin C was once thought to be associated with immunity mechanisms in the body, but evidence is not very convincing. Early work indicating a direct correlation between blood vitamin-C levels and complement formation has not been conformed. On the other hand, a controlled experiment of Glazerbrook and Scott Thompson, in 1938 seemed to show a definite increase in the resistance of schoolboys against tonsilitis, pneumonia, and acute rheumatism—but not colds—when they were given full doses of vitamin C. There is evidence that vitamin C is bacteriostatic, but only in concentrations that could never be

reached in the body. Large quantities of vitamin-C are often given to patients with infections because their excretion of the vitamin is diminished, but whether the vitamin-C level in the tissues and blood of the normal person affects his susceptibility to infection or the virulence of the attack is improven. Vitamin-A has been named the "anti-infective vitamin" without very firm evidence.

Much work has been done in the last decade on the effect of nutrition in experimental infections in animals but most of it presents such confusing and, at times, conflicting results that it is difficult to draw any general conclusions. Experimental work on viruses, however, has established that the virus and the cells of its host compete for nutrients that are essential for vital enzyme mechanisms in both. If the virus prevents the host cells from utilizing these essential nutrients, and appropriates them for its own purposes, then the host cells will suffer and may eventually die. Conversely, if the virus is starved of some of its essential nutrients, it cannot live. Viruses thrive best in tissues whose metabolism is active—as in the developing hen's egg—and the typical picture of several virus diseases in animals can be markedly altered by a variety of dietary deficiencies. Animals on diets deficient in members of the vitamin-B complex often show a heightened resistance to some viruses, such as that of poliomyelitis, so that if they do become infected the disease runs a mild course. This and the low incidence of poliomyelitis among poorly nourished people may be examples of "starving out the virus." With bacterial and protozoal infections a deficiency in vitamin-B complex generally increases susceptibility to infection. Lack of some members of the B complex produces leucopenia, which interferes with phagocytosis. Interesting as these experimental observations are, we must not assume that they have an immediate application to human problems. Nevertheless, Howie suggests that experiments on mice "offer the best hope of giving shape to the present vague mass of information."

Ed—The Lancet—London: Saturday, December 24, 1949.

FEEDING THE TB PATIENT

An ordinary, but well-prepared and varied diet, consisting of meat, fish, milk products, eggs, citrus fruits, green vegetables, and whole grain cereals, served with definite regularity, has been found to be the best diet for tuberculosis patients.

The quantity of food should be increased about 30 per cent above that required by a normal individual of the same physique, to provide for the increased metabolism of these patients, and to maintain their weight at about normal levels. Obesity is not desirable.

The protein allowance is reasonably high, 100-150 grams daily, in order to provide the body with sufficient material to repair the damaged tuberculous tissues. Animal proteins are considered more valuable than vegetable. Excesses of protein and carbohydrate are inadvisable as they may increase pulmonary ventilation and counteract somewhat the benefits of bed rest. Fats are usually well-tolerated by tuberculosis patients and are conveniently supplied in dairy products, fish and marbled meats. Carbohydrates should consist of fruits, vegetables, cereals and simple desserts. The optimal amount of vitamins, including "A" and "C" are well provided for in this diet. Vitamin "D," however, must usually be added as cod liver oil or concentrate. As far as possible, patients should be given their calories in the kind of food they are accustomed to and like. Between meals, feedings are best omitted. Patients should be taught that although milk is beneficial, a varied diet is even more so.

Proper dietary management is only one facet of intelligent and sympathetic patient management. In tuberculosis, the interdependence of doctor, nurse, dietician, social and rehabilitation worker is especially marked.

Feeding The TB Patient, Samuel Phillips, M.D., NTA Bull., January 1950.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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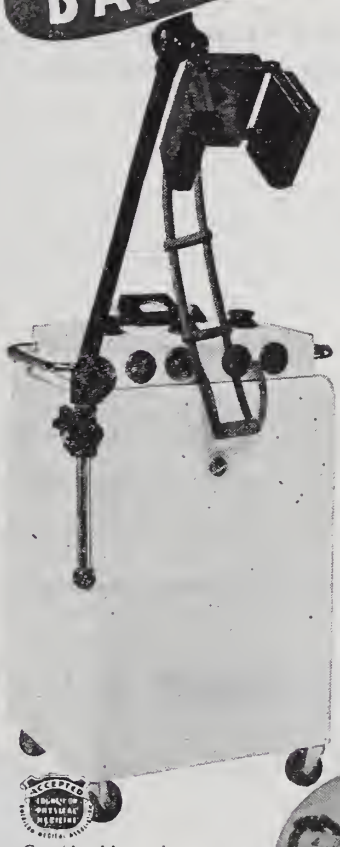

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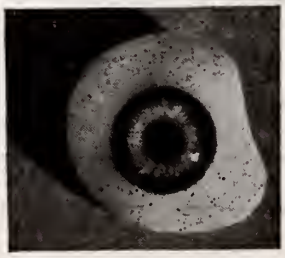

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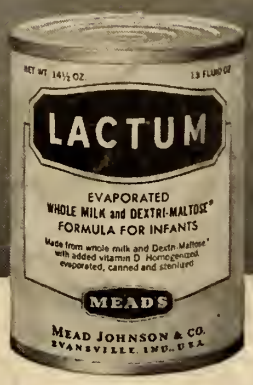

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CONTENTS—Pages 453 to 496

EDITORIALS— Page

President's Message: The Welfare Committee 453
James F. Norton, 1892-1950 454

ORIGINAL ARTICLES—

Massive Hemorrhage from the Upper Gastro-Intestinal Tract—Henry J. Tumen, M.D., Philadelphia, Pa. 455

Ectopic Pregnancy in a Rudimentary Tube—Frederick S. Taber, M.D., New Brunswick, N. J. 464

Management of Breech Delivery—Herbert F. Johnson, M.D., Camden, N. J. 465

Removal of Intra-ocular Foreign Bodies—A. Russell Sherman, M.D., Newark, N. J. 469

Treatment of Rheumatoid Arthritis With Pregnenolone—John A. Strazza, Jr., M.D., Bloomfield, N. J. 472

Treatment of Rheumatoid Arthritis by the General Practitioner — Herman H. Tillis, M.D., Newark, N. J. 475

Hematology: Its Past and Future—Lowell A. Erf, M.D., Philadelphia, Pa. 479

The Miracle of Sudden Sight—B. Bernard Gurland, M.D., Bayonne, N. J. 480

ORIGINAL ARTICLES— Page

Diagnosis of Cancer of the Colon—Hyman I. Goldstein, M.D., Camden, N. J. 482

Decreasing Mortality After Gynecologic Operations—Benno Tunis, M.D., Newark, N. J. 483

Bleeding Meckel's Diverticulum—Thomas V. Morton, Jr., M.D., George L. Kline, M.D., and Nathan Zuckerberg, M.D., Newark, N. J. 486

STATE ACTIVITIES—

Courses in Chest Diseases 468
Memo for Nonveteran Physicians 481
Room-Finding Service for Florida Patients 482
Graduate Medical Courses at Seton Hall 487
Evolution of the Welfare Committee 488
Supplementary List of Members No. 6 489
A.M.A. Session for General Practitioners 490
Diabetes Detection Drive 490
Home for Cardiac Children 491

OBITUARIES 491
PUBLIC HEALTH NEWS 492
BOOK REVIEWS 493
TUBERCULOSIS ABSTRACTS 495

Roster of Officers and Committee Chairmen, Advertising Page 3A

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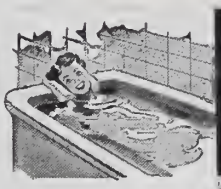

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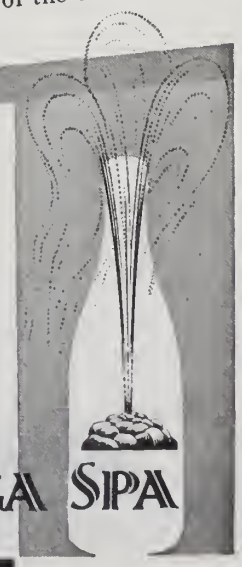

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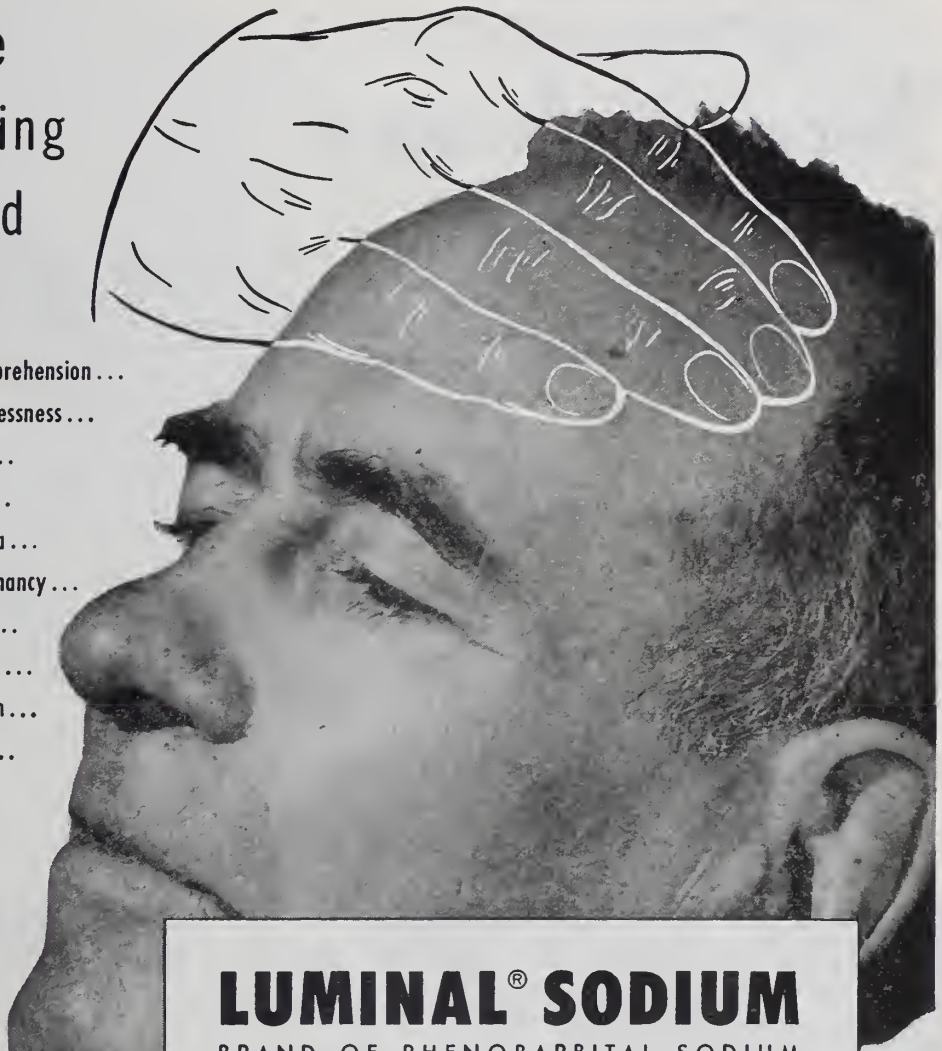

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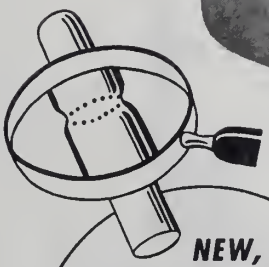

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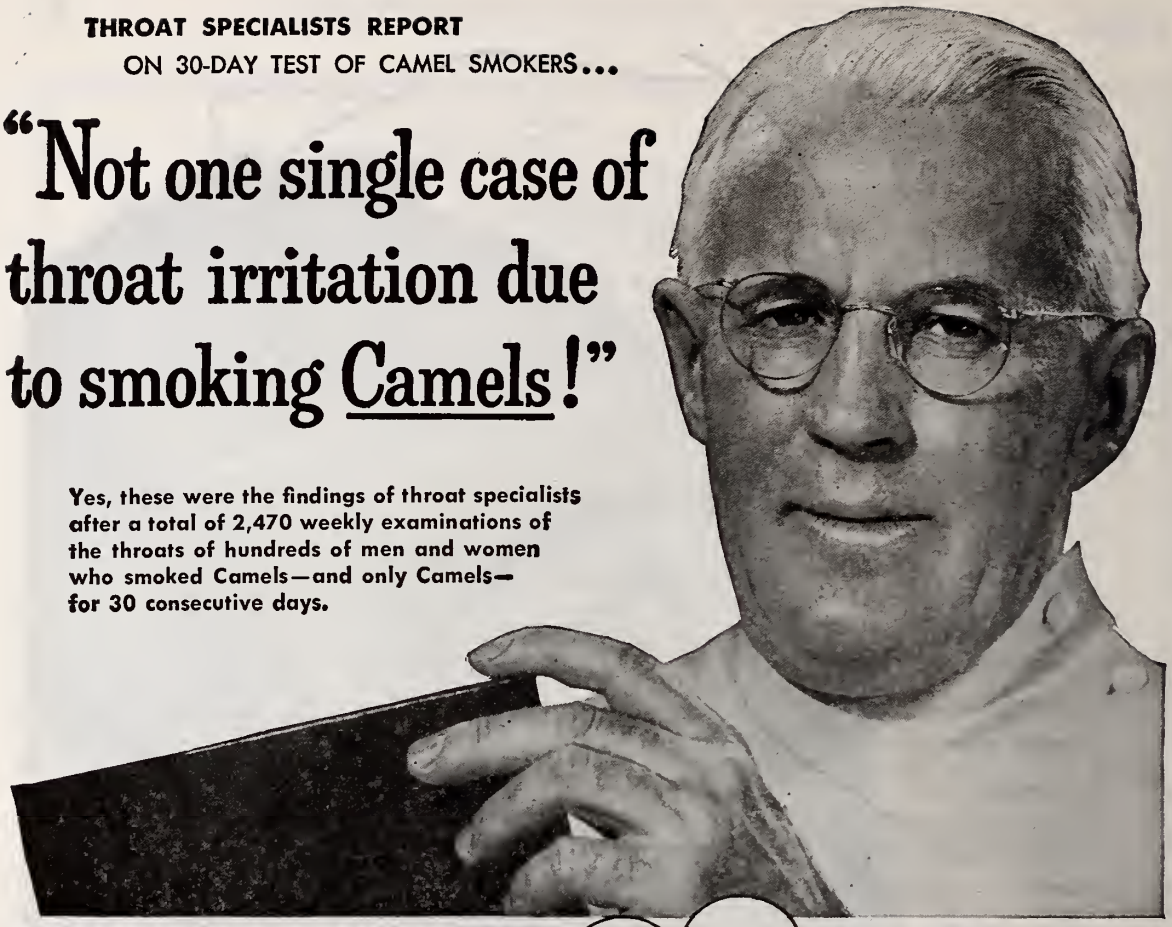
NEW YORK, N. Y. WINDSOR, ONT.

Luminal, trademark reg. U. S. & Canada

THROAT SPECIALISTS REPORT
ON 30-DAY TEST OF CAMEL SMOKERS...

"Not one single case of throat irritation due to smoking Camels!"



Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors Smoke Camels

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

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Physiologically Standardized

Therefore always Dependable

Each Pill is equivalent to one U.S.P. Digitalis Unit

Clinical samples sent to physicians on request

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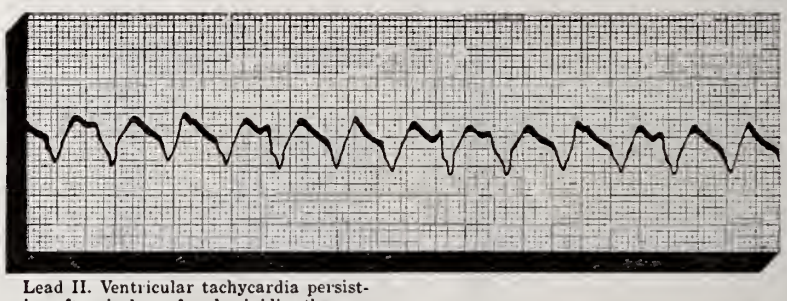
D 22

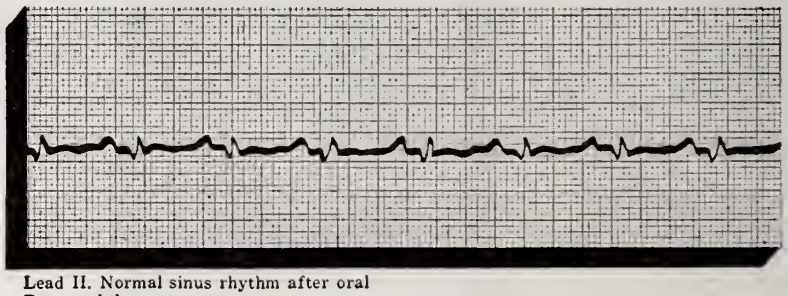
A New Drug..for the treatment of ventricular arrhythmias

BEFORE



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).

AFTER



Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Effective in some patients with ventricular tachycardia who failed to respond to quinidine

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride

SQUIBB

"PRONESTYL" IS A TRADEMARK OF E. R. SQUIBB & SONS

new product brief

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride

for the treatment of ventricular arrhythmias

What is it?

Pronestyl Hydrochloride is Squibb procaine amide hydrochloride. Structurally, Pronestyl differs from procaine only by the presence of the amide grouping (.CO.NH.) in Pronestyl where procaine has the ester grouping (.CO.O.)

How does it act?

The action of Pronestyl is probably due to a direct depressant action on the ventricular muscle. In auricular arrhythmias, preliminary observations indicate that Pronestyl slows auricular rate but usually does not re-establish normal sinus rhythm. At present, Pronestyl is not recommended in the treatment of auricular arrhythmias.

When is it indicated?

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

What are its advantages in ventricular arrhythmias?

As compared with quinidine: Unlike quinidine, no important toxic symptoms bave been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce tbe nausea, vomiting, and diarrhea often caused by quinidine. At higb oral dosage, tbese symptoms may appear.

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

As compared with procaine: For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

What are its side effects?

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

What is the dosage?

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

ORALLY: 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

For the treatment of runs of ventricular extrasystoles:

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

INTRAVENOUSLY: 100-500 mg. (1 to 5 cc. Pronestyl Hydrochloride Solution). *Caution – administer no more than 200 mg. (2 cc.) per minute.*

How is it supplied?

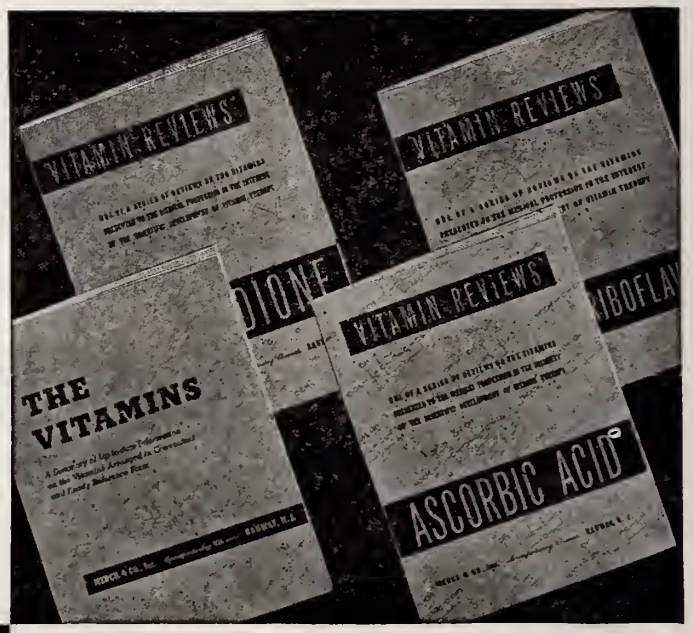
Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.

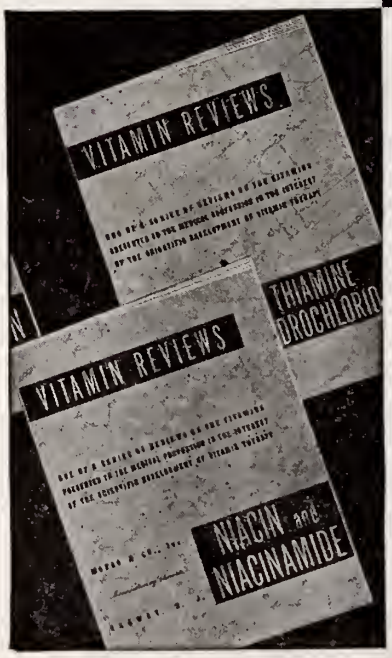
Pronestyl Hydrochloride Solution, 100 mg. per cc., in 10 cc. vials.

SQUIBB

Concise Vitamin Facts

From Merck & Co., Inc. —where many of the individual vitamins were first synthesized.





These six Merck *Vitamin Reviews* are yours for the asking while the editions last. These concise reviews contain up-to-date, authoritative facts and can be most useful for quick reference. Please address requests for copies to Merck & Co., Inc., Rahway, N. J.

Partial Index of Contents

- Factors that produce avitaminosis.
- Signs and symptoms of deficiency.
- Daily requirements and dosages.
- Distribution in foods.
- Methods of administration.
- Clinical use in specific conditions.

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Manufacturing Chemists
RAHWAY, NEW JERSEY

MERCK

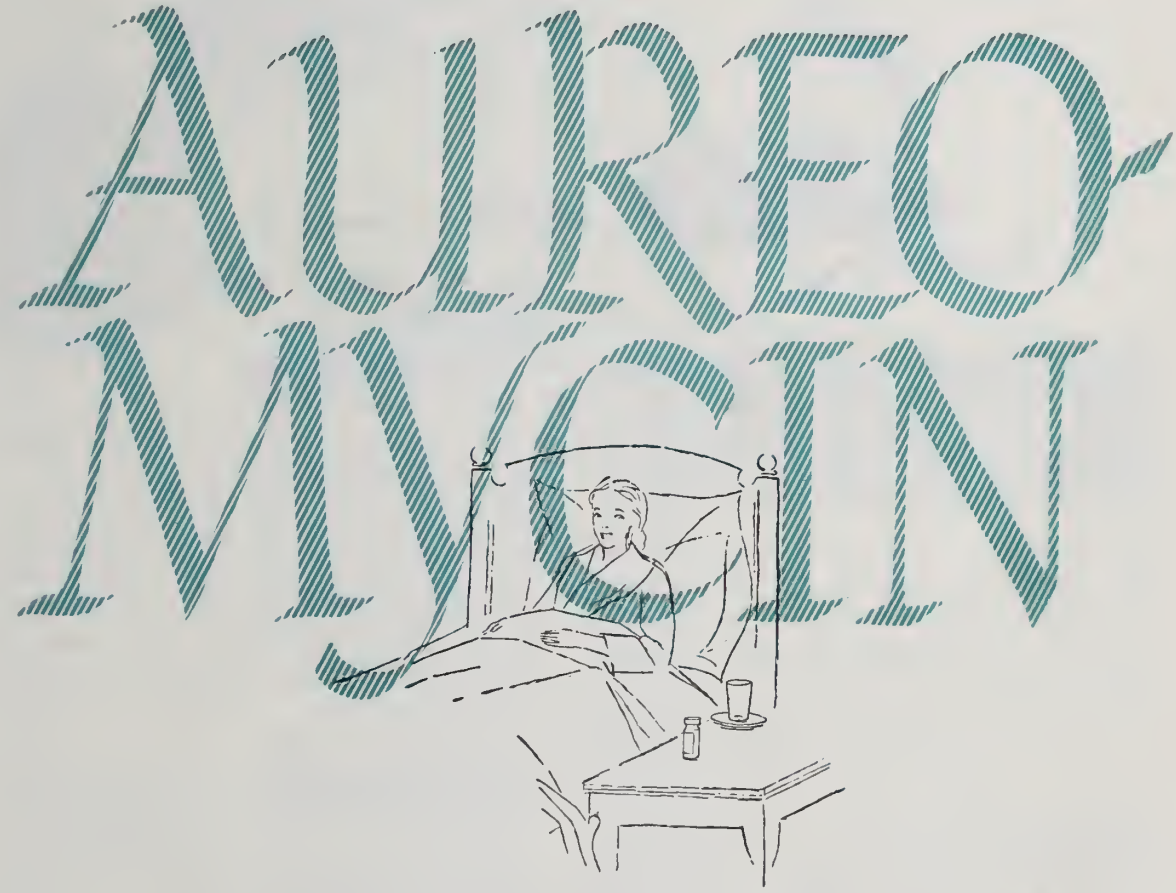
MERCK VITAMINS are available under the labels of leading Pharmaceutical Manufacturers in appropriate pharmaceutical forms

AUREOMYCIN CRYSTALLINE

in Tularemia

Tularemia, which is a serious problem in many parts of this country, can be successfully treated with aureomycin.

All types of tularemic infection, with or without complications, respond promptly to the administration of this antibiotic.



AUREOMYCIN has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), and typhus.

Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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for infant feeding

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PHYTOTONE is compatible with any infant formula...does not cause curdling of the milk. It may be added to the formula or to whole milk, fruit juices, or cereals. Recommended intake is 2 teaspoons per day until one year of age and then 1 tablespoon daily.

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- The container we furnish for used diapers sprinkles its soiled contents with an efficient antiseptic solution whenever the container lid is opened and closed.
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- A modern tested diaper supply service for our customer's exclusive use.

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Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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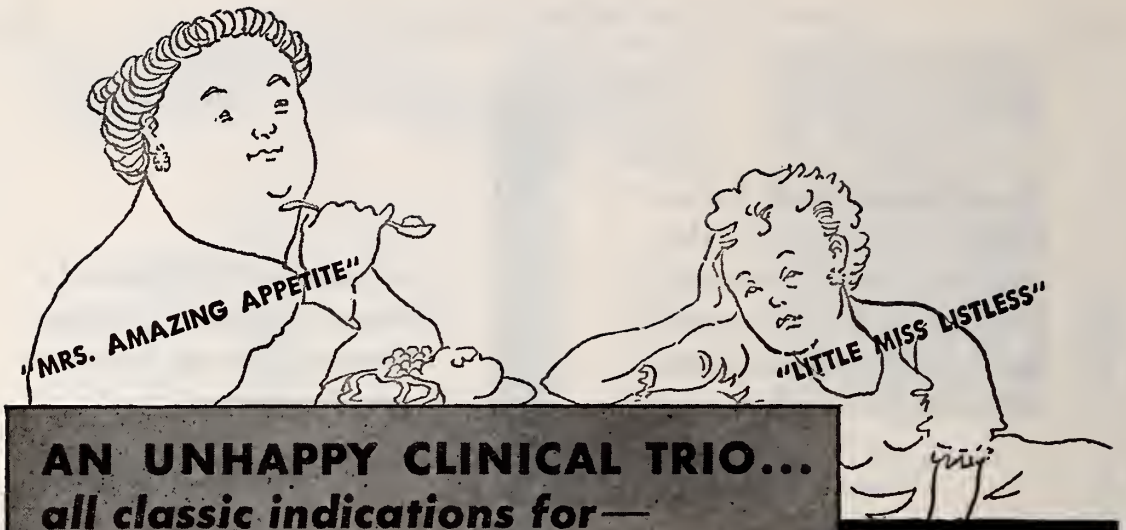

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(BRAND OF METHAMPHETAMINE HYDROCHLORIDE)

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...a potent central stimulant which:

- brightens the depressed "Miss Listless" by imparting a feeling of increased vitality
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A urinary tract infection

Resistant to "... *all available antibiotics and chemotherapeutic agents.*"[1]

TREATED WITH TERRAMYCIN

M.F., male, age 48

History: Pyelonephritis, 1½ years' duration following ureterocutaneous implants (mixed infection: P. vulgaris, E. coli, Staph. albus, enterococci); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Therapy: Terramycin, 2 Gm. daily for 5 days; orally in divided doses q. 6 h.

Result: Urine culture negative except for P. vulgaris by 2nd day of treatment. Response described as "good".

CRYSTALLINE
Terramycin
HYDROCHLORIDE

New Council-accepted broad-spectrum antibiotic orally effective — well tolerated

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

1. Terramycin may be highly effective even when other antibiotics fail.[1]
2. Terramycin may be well tolerated even when other antibiotics are not.[2]

suggested for: *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.*

Dosage: 2 to 3 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25;
50 mg. capsules, bottles of 25.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R.B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950

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raises gastric pH to
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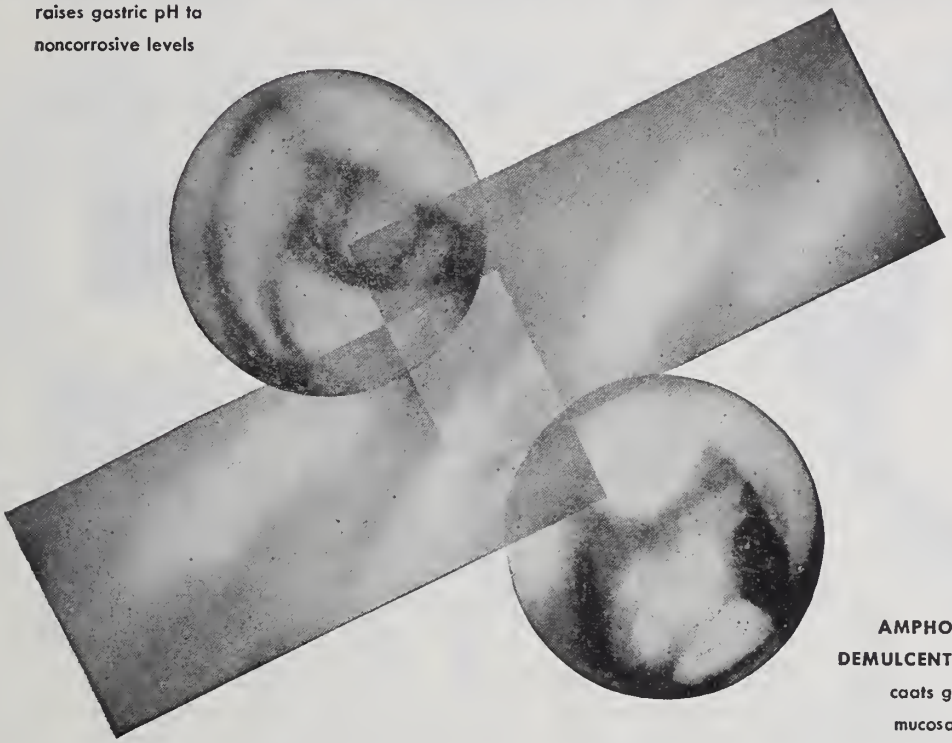

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Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

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CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm	VITAMIN C	30.0 mg.
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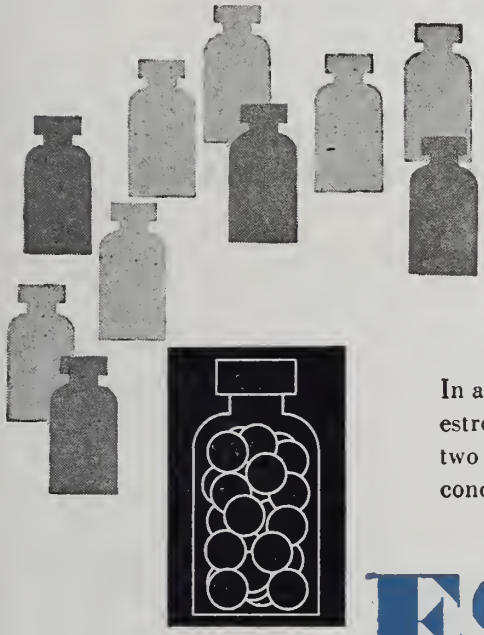
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



10

Estrogens were compared

In a recent clinical comparison of ten estrogens administered by various routes to two hundred menopausal women, the conclusion was reached that:

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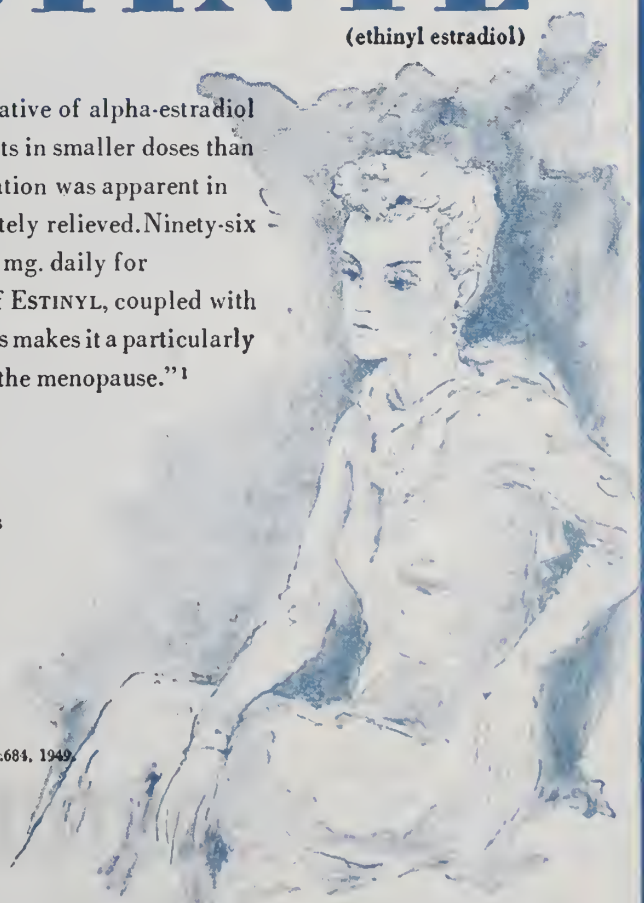
(ethinyl estradiol)

"Ethinyl estradiol (ESTINYL) is a potent relative of alpha-estradiol . . . and it produces its pharmacological effects in smaller doses than any other drug known. . . . Ease of administration was apparent in that 94.2 per cent of all patients were completely relieved. Ninety-six per cent of these required no more than 0.05 mg. daily for satisfactory maintenance. . . . The economy of ESTINYL, coupled with its ability to produce rapid relief of symptoms makes it a particularly useful medication for the routine therapy of the menopause."[1]



DOSAGE:
ESTINYL Tablets. Mild menopause requires one to two 0.02 mg. tablets daily. Moderate menopause requires one 0.05 mg. tablet. Severe menopause may require three 0.05 mg. tablets.

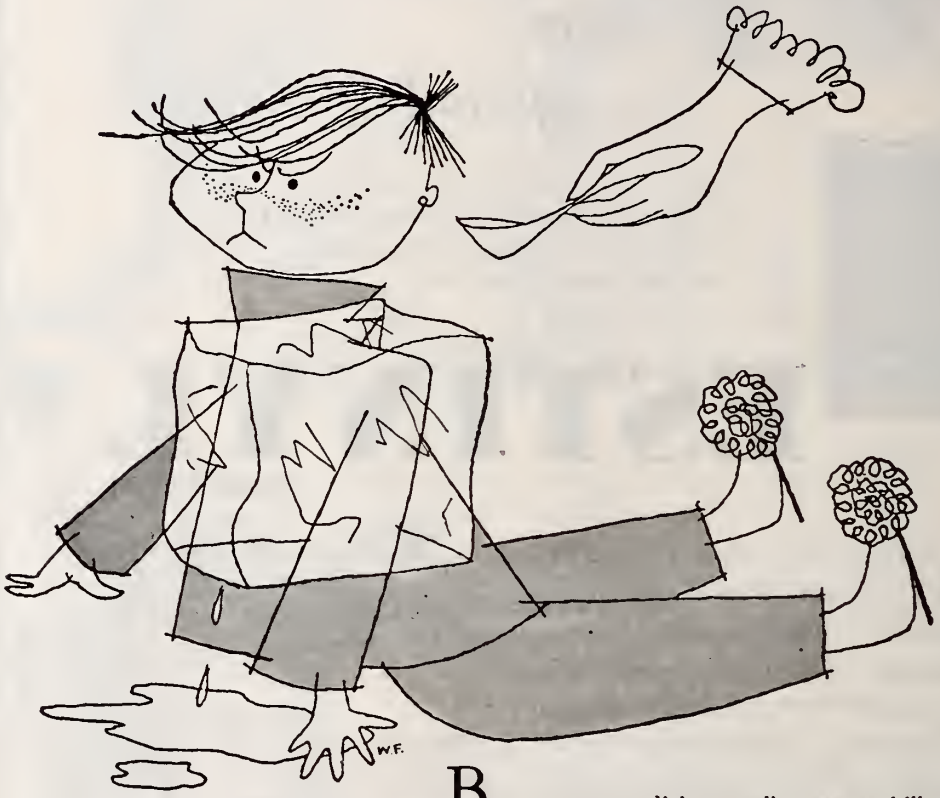
PACKAGING:
ESTINYL Tablets of 0.02 mg. (buff) and 0.05 mg. (pink) in bottles of 100, 250 and 1000. Also 0.5 mg. in bottles of 30 and 100 tablets.

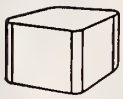
1. Perloff, W. H.: Am. J. Obst. & Gynec. *58*:684, 1949.

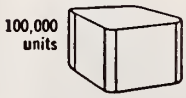
Schering CORPORATION • BLOOMFIELD, NEW JERSEY

ESTINYL

When little patients turn a cold shoulder







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is usually an active participant.
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Lilly

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*M.S.R.—Lilly Medical SERVICE Representative

A 19" x 12" reproduction of this illustration by Robert Riggs is available upon request.

harvesting seaweed for the laboratory

Kelp is first brought up from the bottom of the sea and then carried to a mountaintop in the process of becoming the "laboratory dining table" for germs. The cool air bleaches it nearly as white as the surrounding snow; oriental seaweed then becomes commercial agar. This material is essential to the bacteriologist because it makes possible the preparation of pure bacterial cultures in solid media which do not melt during incubation. Used in both research and production, agar continues to assist the Lilly Laboratories in furnishing physicians with dependable biologicals.

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PRESIDENT'S MESSAGE: THE WELFARE COMMITTEE

Unique among state medical society bodies, is our Welfare Committee. No other medical society has any unit which corresponds exactly to the Welfare Committee of The Medical Society of New Jersey. Ordinarily a medical society is organized at its operational level, into a series of committees, all of equal standing, each working independently, each reporting to the president or to an executive Board. This makes for simplicity but suffers from the fact that medicine is not neatly divisible into air-tight compartments. Under the traditional multiple-committee method, it is quite possible—indeed it is common—for various facets of the same problem to be considered by separate committees, each being in the dark about the parallel labors of other committees. Under this arrangement, for instance, a bill to license clinical laboratories would be under study by a legislative committee and also by a committee on laboratory medicine, and, conceivably, the two committees might work at cross-purposes. A proposal to establish day nurseries for the children of indigent mothers might well fall within the jurisdiction of four or five independent committees. Under New Jersey's Welfare Committee system, such problems would be referred by the Welfare Committee to the appropriate subcommittees and advisory committees; and their reports in turn would be woven together into an integrated pattern before being submitted to the Trustees or Delegates. This points up one of the great values of our Welfare Committee: integration.

Since every county society is represented on the Welfare Committee, the latter lies on the beach-head of a two-

way channel. On the one hand the suggestions of individual members and county societies can flow to the state society through resolutions introduced by that county's members on the Welfare Committee: and conversely, each member of that committee can return to his own county and report directly to the membership on the thinking and activities of the state society. Thus the Welfare Committee is not only an integrating body; it is also a superior medium of direct, two-way communication.

The Welfare Committee performs a third and equally valuable function. It is a large scale sounding board—a forum where matters can be discussed thoroughly. The meeting of mind with mind is an essential instrument of the democratic process. Our Welfare Committee furnishes the meeting ground. An ordinary small committee may have sessions at which only one or two members attend; often one member dominates. A problem cannot get a real airing under such circumstances. But the Welfare Committee, with many dozens of members in attendance at every session, provides the dimensions needed for a realistic and thoroughgoing discussion.

Reviewing the early history of the Welfare Committee, one would never have been able to guess its present structure or function. I have asked our editor to write a capsular summary* of the evolution of this unusual committee. The history of the committee is a good example of an honest and democratic evolutionary process at work.

The Welfare Committee is very much the member's own unit. Any individual member can ask his county representative to present a matter for the Welfare Committee's consideration. Or better yet, he can ask his own county society to adopt an official resolution urging Welfare Committee consideration of any subject. The Welfare Committee is not an aloof group of high officials placed somewhere in the far distance. It is with you all the time because its arms and legs and ears and eyes are right at your county society meetings. It is there to serve you. Let us hope that you will use it often.

Aldrich C. Crowe, M.D.

JAMES F. NORTON, 1892-1950

As we go to press, the Society's office hears the shocking news that Jim Norton is dead. He died in harness and from his own point of view, this was probably the best way to go. Suddenly, at the height of his career, no prolonged period of illness, pain or disability, a busy dynamic day as usual and then suddenly, eternal peace. But from our point of view it is a grievous tragedy.

Jim Norton had just concluded an exciting year as President of The Medical Society of New Jersey and as Vice-President of the American Medical Association. During that year he had catapulted our state society into a position of prominence on the national scene. He had taken the leadership, both locally and nationally, in offering the American public a positive approach to the problem of health insurance. In his own impressive way, standing erect on a hundred speakers' platforms, propounding his thesis with clarity, vigor, and wit, speaking with easy simplicity and flawless prose, he had become the symbol of re-invigorated leadership for American medicine. And now that potent, classic, voice is forever stilled.

In next month's Journal there will be published the formal obituary, the of-

*See page 488, this Journal.

Continued on page 487

MANAGEMENT OF MASSIVE HEMORRHAGE FROM THE UPPER GASTRO-INTESTINAL TRACT*

Henry J. Tumen, M.D., Philadelphia, Pa.

In planning the therapy of massive hemorrhage from the upper gastro-intestinal tract, three major problems require detailed consideration. These are (1) determination of the cause of the bleeding, (2) treatment of the acute emergency which this has produced, and (3) the healing or removing of the underlying lesion to prevent future symptoms, including recurrences of hemorrhages. The order in which the first two steps is taken may be altered by the gravity of the situation. The physician is often forced to treat the shock resulting from the hemorrhage and to attempt to stop the bleeding even before he has discovered its source. Diagnostic procedures, of even the simplest type, must often be deferred until the acute emergency has passed.

EXAMINATIONS DURING THE ACUTE EMERGENCY

When the bleeding has been very severe, even the taking of a complete history and the performing of a routine physical examination may place unwarranted strain upon the patient. If possible, the preliminary history should be obtained from some other member of the family. If the patient himself must give the history, questioning should be restricted to brief inquiries — chiefly concerning previous gastro-intestinal symptoms, as well as digestive distress just prior to the hemorrhage, the occurrence of hemorrhages in the past, the presence of bleeding from other portions of the body, dysphagia and recent weight loss. The physical examination should also be carried out without exhausting the patient. Gentle palpation for abdominal masses and for enlargement of the liver and spleen, and inspection for jaundice, spider nevi, distended abdominal wall veins and for purpura and bleeding from visible mucous surfaces must often suffice in the severely shocked patient.

It is imperative to note the blood pressure and pulse rate at the initial examination and to record these at thirty minute intervals until the acute emergency has passed. As in all types of hemorrhage and shock, falling or persistently low systolic and pulse pressures and rapid and rising pulse rate indicate continuing bleeding and failure of stabilization of the peripheral circulation. A trend of these toward normal usually signifies cessation of hemorrhage.

Careful recording of the urinary output is a further guide to the patient's condition. Low urine output is usually due to circulatory disturbances secondary to shock and to fluid loss and inadequate fluid intake. Knowledge of the urinary excretion is of great assistance in the proper control of fluid administration.

The initial laboratory studies should, of course, include determinations of the red cell count, hemoglobin and hematocrit. These may be relatively normal immediately following even a large hemorrhage. The blood count may not reflect accurately the amount of blood lost for 24 to 48 hours, until blood volume has been restored, and corresponding blood dilution taken place, as a result of entrance into the blood vessels of fluid derived from the tissues plus that which is administered parenterally. The initial blood count, therefore, is often no indication of the severity of a hemorrhage and counts should be taken on successive days.

Blood typing should be done at the time of admission and blood suitable for transfusion be made available. The blood urea nitrogen should also be determined. This is usually moderately elevated following upper gastro-intestinal hemorrhage, largely as a result of the absorption of blood from the bowel. Other causes which contribute to the azotemia are dehydration, disturbed kidney function resulting from shock, anemia and anoxemia, and antecedent renal disease. An excessively high blood urea nitrogen level (above 75 milligrams per cent) usually indicates some complicating kidney disturbance in addition to the absorption of blood and, in general, is of grave sig-

* Read before the Section on Gastro-Enterology and Proctology, The Medical Society of New Jersey, 184th Annual Meeting, Atlantic City, May 24, 1950.

nificance. The death rate is appreciably increased above the average in patients whose blood urea nitrogen level exceeds 100 millimeters per cent so that this determination is of some value as a guide in prognosis.[1] Blood chloride and carbon dioxide combining power readings are also helpful in measuring the severity of chemical disturbance secondary to hemorrhage.

If it is suspected that one of the blood dyscrasias may be the reason for the hemorrhage, appropriate studies—platelet counts and bleeding and clotting times—should be done. The prothrombin level should also be noted. A lowered prothrombin reading usually indicates that liver disease has caused (or contributed to) the bleeding but this need not be the case. Occasionally, the prothrombin drops with bleeding from an ulcer, probably as a result of loss to the body of the prothrombin in the extravasated blood. In any case, prothrombin readings furnish a guide to the need for vitamin K therapy.

The bromsulfalein test is also a valuable adjunct in the early study of the bleeding patient. It has been pointed out before[2] that bleeding rarely, if ever, occurs from esophageal varices due to cirrhosis until the cirrhosis has reached a sufficiently advanced stage to cause a demonstrably abnormal response to this test. This has been confirmed by the recent reports of White[3] and Zamcheck[4] and their associates. If a massive hemorrhage is the result of varices caused by cirrhosis, moderate to marked bromsulfalein retention will be found. If, however, hemorrhage is due to some other cause, there will generally be no dye retention. A slight degree of retention may occasionally result from the temporary liver dysfunction which arises from anemia and anoxemia. Under these circumstances, repeating the test after the acute emergency has passed will generally reveal rapid return to normal of the results of the bromsulfalein test; persistent bromsulfalein retention will be found only if the patient has cirrhosis. This test is simple to perform and is safe to use even if the patient is acutely ill. In view of recent reports of the value of esophageal tamponade in controlling bleeding from varices, every effort should be made to discover the existence of these and the bromsulfalein test helps greatly in this respect.

All of these procedures increase the doctor's ability to evaluate the severity of bleeding and aid him, to a degree, in determining its cause. They can be performed without disturbing the patient a great deal and without delaying the institution of measures to meet the emergency created by the hemorrhage.

TREATMENT OF THE ACUTE EMERGENCY

The patient should be at absolute bed rest. This should be insisted upon even if the hemorrhage is apparently slight and has caused no symptoms other than passage of a black stool. Bleeding often begins in a very moderate manner and, though this may be checked by proper treatment, bleeding may become massive if continued activity is permitted. Usually, of course, the severity of the hemorrhage and the resulting shock make the need for bed rest obvious. If shock is marked, elevation of the head of the bed and external application of heat are advisable. Oxygen administration is beneficial during the period of emergency.

Sedatives should be used in sufficient quantity to keep the patient quiet and to allay the alertness and restlessness so common during hemorrhage. Sodium phenobarbital by injection is the best drug for this purpose. Morphine should be avoided because it occasionally causes nausea and vomiting. If adequate rest is not given by phenobarbital, small doses of dilaudid† are generally satisfactory.

The older fears concerning the administration of blood transfusions early in the treatment of massive gastro-intestinal hemorrhage have largely been dispelled by the recent improvements in transfusion technics. Blood should be given generously to patients in shock or who present evidence that blood loss has been large. The blood pressure and pulse rate are good clinical guides to this and a steadily

1. Schiff, L., and Stevens, R.: Archives of Internal Medicine, 64:1239 (1939).
2. Tumen, Henry J., in Bockus, *Gastro-Enterology*. (Volume 3.) Saunders, Philadelphia (1946).
3. White, F. W., and Chalmers, T. C.: Transactions of the Association of American Physicians, 61:253 (1948).
4. Zamcheck, N. *et al.*: Gastro-Enterology, 14:343 (February 1950).

† Dilaudid is the registered trade name of the Bilhuber-Knoll brand of dihydro morphinone hydrochloride.

falling systolic pressure (particularly if this falls below 100), and a rapid and rising pulse rate are indications that blood replacement is needed. The amount of blood required will, of course, vary considerably. If severe shock exists, it may be necessary to give as much as 2000 cubic centimeters during the first 12 to 24 hours, rapidly at first and at a slower rate of 250 to 300 cubic centimeters per hour as the blood pressure rises. This large amount is not needed in lesser hemorrhages without severe shock and smaller intermittent transfusions can then be given. If, however, active bleeding continues, liberal transfusions must be continued regardless of the amount required. Every hospital should have blood available for emergencies of this type. Great care should be taken, of course, by careful cross typing of the patient with each prospective donor, to avoid transfusion reactions. If compatible blood is not available (or while waiting for this to be obtained) the emergency need for blood replacement can be met by using plasma, preferably irradiated plasma to reduce the likelihood of transmission of viral hepatitis.

Blood transfusions should be supplemented by normal saline or glucose solution intravenously or by hypodermoclysis if the patient cannot maintain an adequate fluid intake by oral feedings. These additional fluids should be given in an amount sufficient to insure a urinary output of at least 1000 cubic centimeters daily. In general, this calls for a total intake of 3000 cubic centimeters daily, including the blood that is given. Vitamins C and B should be added to the parenterally given fluids, and also vitamin K in a daily dose of 5 to 10 milligrams.

It has occasionally been recommended[5] that a tube be introduced into the stomach for the purpose of keeping it empty and also to afford information about the continuance of intragastric bleeding. This is usually not advisable. There is risk in passing a tube unless one is certain that the bleeding is not due to esophageal varices. A bleeding lesion in the stomach itself may be traumatized or a forming clot may be disturbed by a tube. A tube is also likely to be a source of irritation to a patient who is badly in need of rest. For these reasons, routine gastric intubation is not recommended although gastric decompression may be necessary, on rare occasions, to relieve patients with bleeding duodenal ulcers who have persistent nausea and vomiting.

When there is evidence that esophageal varices are the source of the bleeding, effort can be made to control this hemorrhage by application of pressure directly to the bleeding area, by esophageal tamponade. Various types of tubes have been perfected for this purpose—since the method was first suggested by Rowntree and his associates.[6] Parton and Johnston[7] describe a 4 lumen tube by means of which the esophageal veins can be compressed and the stomach aspirated to determine the presence of further bleeding. Use of tubes of this type to control esophageal bleeding has already been successful in saving a number of lives.

There is still a great deal of controversy regarding the diet to be used following upper gastro-intestinal bleeding. The older practice of giving nothing by mouth for 2 to 3 days after a massive hemorrhage has been abandoned. Feedings are withheld only from those who are in shock or who are nauseated and vomit. Other patients usually tolerate small feedings quite well. Initially, 2 to 4 ounces of albumin-water or of 3 to 5 per cent gelatin solution can be given hourly. Usually, however, the patient can tolerate milk and feedings of 4 ounces of milk, or 3 ounces of milk and 1 of cream may be given each hour while awake. More recently, protein milk feedings have become popular. They are widely used because of the need for adequate proteins and calories during the post-hemorrhagic period and because of the buffering effect of proteins on the gastric acid. A satisfactory formula is one such as that given by Rusk,[8] which follows:

5. Soper, E. W., Journal of the American Medical Association, [illegible]
6. Rowntree, L. G., et al., Journal of the American Medical Association, [illegible]
7. Parton, T. B., and Johnston, C. G., Archives of Surgery, [illegible]
8. Rusk, A., The Medical Clinics of North America, [illegible]

Liquid skimmed milk.....1 quart
Cream (20 per cent).....1 pint
Skim milk powder.....8 ounces
Dexin ..... 4 ounces
3 raw eggs
Four ounces of this are given hourly while the patient is awake.

This type of hourly feeding can be continued during the early period of observation until studies lead to a definite diagnosis. Following these, if ulcer is demonstrated, there can be gradual transition to one of the standard ulcer diets. Even early in the post-hemorrhagic period, however, it is usually safe to supplement the milk formula feedings by adding hard candies, prune and other juices, strained cream soups and jello and custards.

Many physicians follow the teaching of Meulengracht[9] and use (even immediately following a hemorrhage) a relatively full diet which gives the patient cooked cereals, soups, ground meat and fish, and cooked and strained vegetables and fruits. It has seemed to me that a diet of this type is not satisfactory for the treatment of active ulcer and that it is not conducive to ulcer healing. The protein milk formula feedings supply the patient with ample protein and meet all of his nutritional requirements without the risk of possible trauma to the stomach or of the stimulation of excessive acid secretion. I believe, therefore, that there is no justification for the routine use of a form of diet therapy such as that advocated by Meulengracht.

Drug therapy usually plays a minor role in the management of gastro-intestinal hemorrhage. With the institution of oral feedings, small doses of phenobarbital may be given if a sedative is needed. Antacids are rarely required even if the hemorrhage had been caused by an ulcer. Ulcer pain usually ceases with the onset of bleeding or is readily controlled by the hourly milk feedings. Persistence of pain is, in fact, a rather grave sign and may indicate that active penetration of the ulcer is going on. If definite ulcer pain continues, antacids may be given. The safest to use is probably sodium bicarbonate in an hourly dose of 10 grains, as recommended by Bockus,[10] rather than the non-absorbable aluminum hydroxide gels. There is some slight danger that the latter preparations may, on contact with blood in the small bowel, form a mass of sufficient size and firmness to cause actual intestinal obstruction. Oral vitamin supplements may also be given. Iron in liquid form is also often prescribed, but only after it has been determined that bleeding has stopped and there is no longer any need to rely on observation of the color of the stools as a guide to persistence of hemorrhage.

No effort is made to induce bowel movements during the first three or four days after a hemorrhage. It is sometimes thought that the presence of a great deal of blood in the bowel may lead to "toxic" disturbances, such as moderate fever, and abdominal distention and discomfort. Even if they occur, these symptoms need not be a source of anxiety. When oral feedings are started, the patient may be given prune juice and also moderate doses of mineral oil or milk of magnesia. Digital rectal examination should be done daily. If there is any indication of fecal accumulation in the rectum, oil retention enemas, followed by small saline cleansing enemas should be ordered. Strong cathartics should not be prescribed.

The appearance of the stools should be noted. The stools may continue to be black for three or four days after the bowels begin to move because of accumulated blood from the original hemorrhage. After the stools become normal in appearance, they should be tested daily for occult blood. It is not unusual for positive reactions to be found for as long as ten days after a single massive hemorrhage. Persistence of positive reactions raises the possibility of continued slight bleeding from an ulcer that is not healing satisfactorily or may be a warning that the hemorrhage arose from a neoplasm of the stomach or bowel. In any case, reactions that continue to be positive for blood indicate the need for relatively prompt survey of the patient so that the source of bleeding may be found.

9. Meulengracht, E.: Ars. Medica. No. 2, p. 60 (1938).
10. Bockus, H. L.: *Gastro-Enterology.* Saunders. Philadelphia (1946).

PROCEDURES TO DETERMINE SOURCE OF HEMORRHAGE

Peptic ulcer — gastric, duodenal or post-operative—is the cause of from 60 to 75 per cent of hemorrhages from the upper gastro-intestinal tract.[10] About 95 per cent of the hemorrhages for which a definite cause can be demonstrated can be traced to one of a small group of disorders—ulcer, esophageal varices, gastritis and gastric neoplasms. Statistics of this type, as helpful as they are, may, however also be misleading. They obscure the fact that hemorrhages are occasionally due to rare and unusual causes and also that many hemorrhages (up to 20 per cent in some series) remain unexplained despite intensive studies.[11] The great frequency with which ulcer is the cause of hemorrhage must not blunt diagnostic zeal, lead to too ready acceptance of ulcer as the cause of a hemorrhage or interfere with careful search for other lesions.

Unfortunately, the history and physical examination may not afford the diagnostic assistance needed. Even when ulcer is the cause of bleeding, there have frequently been no characteristic symptoms prior to the hemorrhage to serve as a clue. The routine laboratory procedures rarely give much information about the etiology of a hemorrhage, valuable as they are in portraying its severity. Under these circumstances, the physician must rely upon other methods of study. A major problem in the management of hemorrhage is the decision of the proper time at which these are to be utilized.

In the search for the cause of a hemorrhage, the x-ray examination of the upper gastro-intestinal tract has come to be the critical diagnostic procedure. One no longer asks whether x-ray studies should be made of the patient who has had a hemorrhage but, rather, how soon these should be done. In the past, it was customary to wait about two weeks following massive upper gastro-intestinal bleeding before proceeding with roentgen studies. It was feared that earlier examinations might cause further bleeding. It was not unusual to find, however, that studies at this interval after a hemorrhage often failed to demonstrate a lesion. Since it was felt that the prolonged waiting period might have permitted some lesions to heal, earlier x-ray examinations were advocated (Schatzki).[12] The technic used by Hampton[13] was found to be safe and satisfactory and it has been stated that roentgen studies done immediately after a hemorrhage, or even during it, if the patient is not in shock, result in prompt recognition not only of many ulcers but also of gastric tumors, esophageal varices and hiatal hernias.

While there is much to recommend early x-ray study of patients who have had massive bleeding from the upper gastro-intestinal tract, the procedure has some limitations that must be recognized. There is an element of risk in the transportation and manipulation of patients who have recently bled severely. In addition, the inadvisability of using compression and strenuous palpation during the examination somewhat restricts the study. The latter difficulty can be overcome, to some extent, by carefully rotating the patient and permitting peristalsis and gravity to distribute the barium, but it is still possible that small lesions will be missed. It is also true that an ulcer may not be demonstrated immediately after a hemorrhage because edema of its border or clot that fills its crater prevents barium from entering the ulcer. Positive errors may also arise in early x-ray studies if blood clots displace sufficient barium to simulate the filling defects produced by new growths.

It seems best not to have a fixed time for the x-ray study of patients who have had a hemorrhage. In most instances, examination 10 to 14 days after the hemorrhage will give as much information as earlier studies. Since the earlier demonstration of a lesion will usually not alter the course of events or lead to changes in therapy, it is wise to avoid the slight additional risk that comes with prompter investigation. Immediate x-rays seem unnecessary for patients definitely known to have had ulcers in the past and do not seem advisable if the clinical feature and bromsulfalein test suggest esophageal varices. Early

11. Crohn, B. B. *et al.*: Gastro-Enterology, 10:120 (1948).
12. Schatzki, R.: New England Journal of Medicine, 235:783 (1946).
13. Hampton, A. O.: American Journal of Roentgenology, 38:565 (1937).

roentgen examinations are most helpful in the study of patients who have had previous hemorrhages of undetermined origin and those whose bleeding occurred without antecedent symptoms. They are of particular assistance in planning the management of hemorrhage in older patients, of patients in whom the stools continue to be positive for occult blood beyond the usual time, and of those whose clinical course suggests that surgical intervention may become necessary. In these patients the help that may be obtained in reaching a decision for or against an operation justifies the use of early x-ray studies.

Unfortunately, there are no reports comparing the results of x-ray studies of the same patients immediately and again 10 to 14 days after massive upper gastro-intestinal bleeding and it is not known how many ulcers that can be recognized in early roentgen examinations would no longer be found at a later study. Probably not very many. In skillful hands prompt x-ray examination is of value in the recognition of many lesions and this may be of assistance in planning treatment. If, however, early studies are negative, the examination should be repeated when the patient's condition permits more intensive study. If early x-rays are planned they should be done 24 to 48 hours after massive bleeding has stopped and not while the patient is in shock. The roentgenologist must fully understand the need for extreme gentleness in handling the patient and for avoiding excessive manipulation and palpation and compression.

Because it is the only method by which gastritis can be diagnosed with accuracy, gastroscopy may also be of value in studying the patient who has recently had a hemorrhage. Gastritis is second only to ulcer among the intragastric causes of bleeding and from 1.5 to 10 per cent of gross hemorrhages have been ascribed to this cause.[10] This diagnosis has often been made by inference, however, and the exact importance of gastritis as a cause of bleeding is still unknown. Gastroscopic examination of the patient who has recently bled should not be performed unless x-ray and other studies have excluded the presence of esophageal varices and of lesions which may be obstructing the lower esophagus or cardia. Gastroscopy is usually not needed if x-rays have revealed an ulcer or other lesion to explain the hemorrhage. The examination should be carried out if no definite lesion is found by x-ray and is particularly valuable in studying patients who have had previous hemorrhages for which no cause has been found. It is in such patients, particularly, that gastroscopy may reveal changes in the gastric mucosa, if the examination is done within a few days after bleeding has occurred. Gastroscopy is also of value in deciding whether a hiatal hernia is a source of massive bleeding. Herniae at the esophageal hiatus are common but only rarely cause gross hemorrhage. Occasionally, however, bleeding occurs in the herniated portion of the stomach, as a result of congestive changes and ulceration. In a few instances I have been able to visualize, by means of the gastroscope, bleeding areas in the supradiaphragmatic part of the stomach and to demonstrate that the hernia was, in fact, the cause of the recent hemorrhage.

Recently, it has been advocated that esophagoscopy be performed if there is reason to believe that varices are the cause of hemorrhage (Carver and Zamcheck[14]). It is difficult to accept this as a general procedure although there are undoubtedly exceptional instances in which the examination may be of value if a well trained esophagoscopist is available.

Unfortunately, detailed studies of patients who have had massive hemorrhages do not always lead to a satisfactory explanation of the bleeding. This is the case in as many as 20 per cent of hemorrhages from the upper gastro-intestinal tract.[11] A patient may have only one hemorrhage of undetermined origin; but some bleed repeatedly over periods of years without the cause being found. It is customary in these cases to ascribe the bleeding to ulcers that heal rapidly or to recurring episodes of gastritis. These, however, seem to be incompletely supported theories. Many patients have been subjected to subtotal gastrectomies without any lesion being found in the stomach or

14. Carver, N. G., and Zamcheck, N.: New England Journal of Medicine, 242:280 (1950).

duodenum and a few have even been studied at autopsy[15] without demonstration of the cause for the bleeding. The fact that many patients with bleeding of this type never have any significant digestive symptoms makes it seem unlikely that they have any well-defined gastric or duodenal disease. It may be that other acute disturbances of the gastric mucosa —of allergic or vasomotor origin—may cause hemorrhages, though little is known of these.

These mysterious hemorrhages present tremendous diagnostic difficulties. When they occur only once, a diagnosis of a rapidly healing ulcer or of transient gastritis may be acceptable but this is not the case when bleeding occurs repeatedly. Under these circumstances a detailed diagnostic program should be followed. There should be a search for allergies to food and sensitivities to drugs such as aspirin (Douthwaite and Lintott[16]). The examiner should look for telangiectatic areas in the mouth and pharynx as a clue to the possibility of similar lesions in the stomach. Complete hematologic examinations should be carried out. The string test of Einhorn may be helpful in locating the bleeding area. These patients should, of course, have most detailed and repeated x-ray studies. These should include a search not only for ulcer but also for hiatal hernia, esophageal lesions, small tumors of the stomach and, if melena has been the only form of bleeding, small bowel lesions. Because of the need for every diagnostic assistance, there is justification for early x-ray studies of these patients and also for early gastroscopic examination which, if done shortly after the hemorrhage, may bring to light hemorrhagic gastric mucosal changes. In other words, the investigation of a patient with repeated hemorrhages and no easily found lesion is difficult and time consuming. Unfortunately, it may also be disappointing, because although the causative lesion is often found as a result of painstaking search, it is also true that no satisfactory explanation for bleeding may ever be uncovered.

15. Jankelson, I. R.: Gastro-Enterology, 9:472 (1947).
16. Douthwaite, H. H., and Lintott, G. H.: Lancet, 2:1222 (December 1938).
17. Finsterer, H.: Surgery, Gynecology and Obstetrics, 69:291 (1939).

ROLE OF SURGERY

Any discussion of the management of hemorrhage from the upper gastro-intestinal tract must include an opinion on the place of surgery in the treatment of this emergency. Unfortunately, this is most difficult to discuss and there is certainly a marked lack of agreement about it. Internists have often advocated purely medical treatment of hemorrhage, but some patients have died because the failure of conservative therapy to control bleeding was not recognized until death was imminent and an operation futile. On the other hand, some surgeons have been extremely radical in their recommendations and have advised that *all* patients with massive hemorrhage be operated upon, particularly if seen shortly after the onset of the bleeding (Finsterer[17]). Such a plan results in a low surgical mortality; but it subjects many patients to unnecessary operations —unnecessary in the sense that bleeding would have stopped in most instances without the operation and also because many patients bleed from lesions that are not amenable to surgical management. Most of the papers dealing with the indications for surgical treatment of upper gastro-intestinal hemorrhages have been written by surgeons. As excellent as most of these papers are, they frequently approach the problem without full consideration of its many facets.

There is first the question of the cause of the bleeding. Operation can be of little benefit unless the hemorrhage is due to a lesion that can be removed or treated surgically in such a way that bleeding can be controlled. The value of surgical treatment is restricted, therefore, largely to bleeding from ulcer and from tumors of the stomach and small bowel. Ulcer has been estimated to cause from 60 to 75 per cent of all massive hemorrhages into the upper gastro-intestinal tract and gastric cancer less than 5 per cent (Bockus[10]). Benign tumors of the stomach and small bowel are such rare causes of hemorrhage that they are of little statistical importance. Surgically correctable lesions, then, cause 80 per cent or less of massive hemorrhage. Even when an ulcer is the cause of the bleeding, the location and penetration of the lesion and its adherence to ad-

jacent organs may make it most difficult to remove or otherwise treat under the conditions of emergency surgery.

Another criticism of routine surgical treatment is that the poor general condition of some of the patients makes them totally unfit for radical surgery. Many who have died without surgery could probably not have been saved by an operation. Finally, it must be emphasized that most patients who bleed recover without an operation. As Welch[18] has so aptly expressed it, "——— even in this older age group (he is speaking of patients older than 50 who have massive hemorrhages from ulcer) two thirds of the patients do not bleed again after entering the hospital; if these patients were all subjected to surgical intervention a number would die from the operative procedure itself, and it is unfortunate to have a patient die from an operation who would have recovered if he had stayed at home".

The problem of surgical intervention in the management of upper gastro-intestinal hemorrhage becomes, therefore, the problem of selecting those patients whose bleeding will probably not respond to conservative medical treatment and who are bleeding from a lesion that can be corrected by operation. The number of such patients is not large and it is not constant. It will vary considerably not only because of inherent differences in the patients encountered but also because of differences in training and viewpoint of the doctors who treat them. A decision regarding surgical intervention to control hemorrhage calls for the most careful application of all that is known of the patient and his illness and requires very sound judgment. While certain rules can be stated, only close consideration of the individual problems of each patient can keep mortality to a minimum.

A number of factors are important in deciding upon the need for an operation. The age of the patient is certainly one significant item. Mortality from hemorrhage is much greater in patients who are over 50 than it is in younger people. This implies that radical measures are more often needed in older patients if their lives are to be saved. Definite knowledge that the patient has an ulcer (derived from a history of typical ulcer pain, with or without antecedent hemorrhages, or from the evidence of x-ray studies carried out early in the course of hemorrhage) aids in deciding in favor of operation, since a specific lesion has been found. Chief indication for surgery is continuing or repeated bleeding from an ulcer in a patient who is being treated conservatively. Most patients stop bleeding soon after admission to the hospital. A small number will continue to bleed. In a slightly larger number, hemorrhage that has stopped will recur. Poor response to conservative measures can usually be readily detected by close observation of blood pressure and pulse rate and by demonstration that excessive amounts of blood (more than 2500 cubic centimeters) are needed to maintain a satisfactory clinical status. Most patients who begin to bleed again do so within a few days. In Welch's experience, 85 per cent of persistent or recurring bleeding was noted by the third hospital day.[18] It is this early post-hemorrhagic period, therefore, which is most critical and during which closest scrutiny of the patient is needed.

The initial therapy of upper gastro-intestinal hemorrhage should be conservative and follow the general lines indicated in the preceding paragraphs. During the early period of hospitalization, closest observation of the patient is necessary with careful evaluation of the response to therapy, particularly to the replacement of blood. If it is possible, the surgeon as well as the internist should become familiar with the details of the situation during this time. Operative intervention should be planned if bleeding persists or recurs despite medical treatment and particularly if the patient is known to have an ulcer and is more than 50 years old. The operation should, if at all practicable, be one which removes the bleeding area. In the case of the ulcer, subtotal gastrectomy with removal of the ulcer is the desired procedure.

SUBSEQUENT TREATMENT

With cessation of the bleeding, detailed diagnostic studies should be carried out to deter-

18. Welch, C. E.: Journal of the American Medical Association, 141:1113 (1949).

mine its source. If x-rays taken shortly after bleeding began did not demonstrate a lesion, these should be repeated, with careful study of the lower esophagus and small intestine as well as the stomach and duodenum. There should also be complete assessment of renal and hepatic function and of the hematologic status. A gastric analysis is also of value in planning future treatment.

The hourly milk formula feedings should be continued during the period of study, with transition to one of the standard rigid ulcer diets if an ulcer is found. Gradually increasing activity can be permitted as strength returns and it becomes certain that bleeding will not recur.

If no specific cause for the bleeding is demonstrated arrangements should be made to study the patient repeatedly over a prolonged period. If studies suggest the presence of a neoplasm, operation should be performed as soon as the general condition permits.

When a definite ulcer is found, a choice must be made between continued medical treatment and an interval operation with subtotal resection in the hope of preventing ulcer recurrences and, particularly, future hemorrhages. Here again, the problem must be individualized—a single massive hemorrhage from an ulcer is, in itself, no indication that the ulcer will not respond to careful medical therapy. The advice that patients who have had one hemorrhage be subjected to interval resection[18] seems unjustified.

Operation is indicated following a hemorrhage if a gastric ulcer is demonstrated and if there is any suspicion that this may be malignant. Surgery is advisable if the ulcer is duodenal and is complicated by pyloric obstruction or marked antral deformity because further medical management is usually unsuccessful under these circumstances. A deeply penetrating posterior wall duodenal ulcer carries a danger of recurrent hemorrhages and (particularly in older patients) its removal is often warranted as a preventive measure. Subtotal resection should also be advised for patients with demonstrable ulcer, gastric or duodenal, if they have had two or more recurrent hemorrhages despite adequate medical care. In other instances, surgical treatment of an ulcer that has bled should be deferred until the response of the ulcer to medical therapy can be evaluated. This is particularly true if the patient has not been under rigid medical management prior to the hemorrhage.

SUMMARY

1. Hemorrhage from the upper gastro-intestinal tract is often so severe that attempts to determine its cause must be postponed until the patient has recovered from the shock caused by the hemorrhage.

2. During the acute emergency, diagnostic studies should be greatly restricted. The blood pressure and pulse rate offer a general guide to the patient's status. Blood counts and hematocrit readings may be somewhat slow in reflecting the severity of the hemorrhage. The bromsulfalein test helps in the recognition of hemorrhage cause by ruptured esophageal varices in cirrhotic patients.

3. Frequent and ample transfusions are the most important feature of treatment of the acute emergency that results from massive hemorrhage. Enough blood should be given to restore the blood volume and stabilize the circulation. Complete rest and adequate sedation are also necessary. Early feeding of the patient is also advisable, but milk or milk-formula feedings should be given rather than the Meulengracht diet.

4. Ulcer is the most frequent cause of massive bleeding from the upper gastro-intestinal tract, even in patients who have had no previous ulcer symptoms. Other important causes are: gastritis, ruptured esophageal varices and gastric neoplasms. In a significant number of patients, however, the cause of a massive hemorrhage cannot be found.

5. X-ray studies are of the greatest assistance in finding the cause of bleeding from the upper gastro-intestinal tract. Examination immediately after bleeding may be of value in determining the source of hemorrhage, particularly if there have been previous hemorrhages of undiscovered cause. In most instances, however, x-ray examinations can be postponed until the patient has recovered from the immediate effects of massive hemorrhage.

6 Conservative medical therapy should be attempted for all patients suffering with massive upper gastro-intestinal hemorrhage. Surgical intervention is necessary only infrequently. It is indicated primarily if it can be determined that bleeding comes from a lesion that can be corrected by surgery and if medical measures fail to control the hemorrhage. An operation is most likely to be successful if bleeding is due to an ulcer. It is extremely difficult to establish rules for surgical intervention in the treatment of hemorrhage. Each patient is an individual problem. In general, operation is advisable if hemorrhage continues or recurs while the patient is being treated by conservative measures.

7. Following recovery from hemorrhage, detailed studies should be carried out to discover its cause. Interval surgery is advisable if there is reason to believe that a malignant lesion caused the bleeding. If an ulcer is found to have been the source of bleeding, surgery should be postponed until the response to medical treatment can be evaluated.

1900 Rittenhouse Square

ECTOPIC PREGNANCY IN A RUDIMENTARY TUBE

UNCONNECTED WITH A UTERUS UNICORNIS

Frederick S. Taber, M.D., New Brunswick, N. J.

Although many bizarre ectopic pregnancies have been cited in the literature, I have been unable to find a duplicate of the case reported below.

A white, para I, age 23, delivered a male infant weighing 3 pounds and 6 ounces on October 22. The patient was estimated to have been at 42 weeks gestation at the time of delivery. We were at loss to explain the small fetus which now is believed to have been due to a uterus unicornis. Four months later, I was called to see the patient who gave the following history. Last menstrual period had been January 1. On February 13, she had experienced sharp lower abdominal pain simulating severe menstrual cramps lasting about two hours. This recurred on February 16 and lasted most of the night. On the next morning, the pain appeared to have subsided but recurred after the patient took a hot shower. She returned to bed and about one hour later fainted when she got up to obtain some aspirin for her pain. There had been no vaginal bleeding.

On arrival the patient was pale and clammy and appeared in obvious discomfort. Pulse was 104. The lower abdomen was somewhat distended and diffusely tender to palpation with voluntary rigidity. Vaginal examination revealed marked tenderness and fullness of the posterior fornix. The uterus was palpated well over to the right side in anteflexion and was moderately tender and enlarged.

The patient was immediately transferred by ambulance to the hospital and operated upon with a diagnosis of ruptured ectopic pregnancy. The peritoneal cavity was found filled with dark blood and numerous clots. After removal of the clots, it was then seen that she had a unicornate uterus with a normal right tube and ovary, held anteriorly by a short, thick right round ligament. On the left side was a normal ovary and a rudimentary left tube suspended from the left lateral insertion of the broad ligament into the pelvic brim. This consisted of the distal half of a tube with normal fimbria and contained the ruptured ectopic pregnancy. The proximal portion of the tube was missing and merely blended into the left broad ligament having no possible connection with any rudimentary left uterine horn. Indeed, the left round ligament was elongated and attached into the cervix where a barely palpable nodule was present, undoubtedly representing an atrophic left uterine component.

The rudimentary left tube with the ectopic pregnancy was excised and the patient made an uneventful recovery. On the second postoperative day she commenced bleeding vaginally and expelled uterine decidua.

The presence of the fertilized ovum in a rudimentary tube unconnected with the uterus is probably best explained by intra-abdominal transmigration of the sperm. It would, of course have been just as possible for a fertilized ovum originating from the right side to have migrated. Unfortunately in the excitement of this interesting anomaly, search for a corpus lutem was omitted.

55 Paterson Street

MANAGEMENT OF BREECH DELIVERY*

Herbert F. Johnson, M.D., Camden, N. J.

Fetal mortality in breech presentation is several times as high as in vertex presentation, even when corrected by deduction for non-viable prematures, and infants with congenital abnormalities not compatible with life. The corrected fetal mortality rates in numerous large series of cases varied from 2 per cent[9] to 11 per cent.[34] Recently, the literature has been more optimistic about fetal mortality and several reports of small series of cases give corrected mortality figures that approach that of vertex presentation.[27, 28, 32, 35] See table 1.

TABLE 1

CORRECTED FETAL MORTALITY RATES

Author	Year	(Per Cent)
Caldwell and Studdiford[2]	1929	11.11
Cannell and Dodek[3]	1934	6.75
Danforth[6]	1938	5.85
Patton and Mussey[21]	1940	3.77
Hawker and Soule[15]	1940	5.84
Goethals[11]	1940	6.9
Tompkins[28]	1943	2.70
Guyer and Heaton[14]	1946	4.50
Dieckmann[9]	1946	1.70
Ware[35]	1947	2.70
Baer[1]	1949	4.0
Dennen[7]	1949	8.73
Phaneuf[23]	1949	6.6

To better our fetal mortality rate in breech deliveries, we began in 1946, to enforce certain regulations in our maternity department.† A member of the inpatient department was present at all breech deliveries, both ward and private. The resident staff was instructed to treat all breech deliveries in a conservative manner, and they were also more carefully supervised. Fewer general practitioners continued to do obstetrics in our hospital. We have taken two comparable groups in order to compare our fetal mortality rates and to see if we had bettered our rates and if our method of treatment was justified. In the first group there were 352 cases of breech presentation, an incidence of 2.6 per cent and in the second group 1946 to 1949 there were 316 cases, an incidence of 2.7 per cent.

Gross fetal mortality. Gross fetal mortality is defined as "all stillbirths and neonatal deaths occurring from the 28th week of pregnancy until term". Rates in the literature show great variation and figures as high as 35 per cent have been recorded.[26] In our two series of cases, the gross fetal mortality rate from 1936 to 1946, exclusive of 1937, was 12.2 per cent for primiparas and 18.8 per cent for multiparas, for all cases 14 per cent. In the second series 1946 to 1949 inclusive, the gross mortality rate was 9.5 per cent for primiparas and 7.7 per cent for multiparas, and 8 per cent for all cases.

Corrected fetal mortality. Some deaths cannot be attributed to the presentation. To arrive at a more accurate rate for the presentation itself, certain deductions are usually made:[26] (1) non-viable prematures, those weighing less than 1500 Grams are deducted. (2) Babies with fatal malformations. (3) Babies dead on admission. No deductions were made for deaths due to prolapsed cords or deaths due to maternal complications such as toxemia of pregnancy. Twin pregnancies were counted only if the first child presented by the breech and then only as one delivery. With the above corrections, in our first series there was 7.7 per cent fetal mortality in primiparas and 11.1 per cent in multiparas, and 8.5 per cent for all cases. In the second group there was 6.6 per cent fetal mortality in primiparas and 5 per cent mortality in the multiparas, and 5.3 per cent for all cases, a favorable reduction. See table 2.

TABLE 2

GROSS FETAL MORTALITY

1936 to 1946

	No. of Cases	Gross Fetal Mortality	Corrected Fetal Mortality
Primipara	181	12.2%	7.7%
Multipara	171	18.8%	11.1%

1946 to 1949

	No. of Cases	Gross Fetal Mortality	Corrected Fetal Mortality
Primipara	136	9.5%	6.6%
Multipara	180	7.7%	5.0%

* Presented at the Annual Meeting of The Medical Society of New Jersey, May 22, 1950.
† At the Cooper Hospital in Camden.

Corrected premature mortality. It is generally assumed by most doctors that babies weighing 1500 Grams or more represent viable prematurity. Our mortality rates, excluding babies who had congenital abnormalities was 19.4 per cent for primiparas in the first series and 37 per cent for multiparas; 21 per cent for primiparas in the second series and 16 per cent for multiparas in the second series. This compares favorably with the mortality rate for all premature babies in our hospital. Dieckmann[9] gives premature mortality as 25 per cent in five large services. Seeley[26] feels there is apparently no indication of an increased risk for viable prematures presenting by the breech. Other authors are not entirely in accord with this statement. See table 3.

TABLE 3

PREMATURE MORTALITY

	Primiparas	Multiparas
1936 to 1946	19.4%	37.0%
1946 to 1949	21.0%	16.0%

Corrected term mortality. An infant weighing 2500 Grams or more is mature[26] in so far as its ability to survive is concerned. Here again, there is considerable variation in the mortality rates found in the literature. Our neonatal and stillbirth mortality in the first series was 4.7 per cent for primiparas and 9.9 per cent for multiparas, for all cases 7.3 per cent. In the second series: 4.1 per cent for primiparas and 2.8 per cent for multiparas, for all cases 3.4 per cent. See table 4.

TABLE 4

TERM MORTALITY

	Primiparas	Multiparas	All Cases
1936 to 1946	4.7%	9.9%	7.3%
1946 to 1949	4.1%	2.8%	3.4%

To account for the high fetal mortality in breech delivery, various factors are named in the literature, (1) *prolapse of the umbilical cord.* The accepted incidence is 0.5 per cent for all positions.[2] In breech deliveries it is found to be 6 to 10 times more common than in vertex presentations. In our series of cases, prolapsed cord occurred in 2.3 per cent of the cases and had a fetal mortality of 14.2 per cent. (2) *birth weight.* Mention is made in the literature several times that the weight of a baby is an important factor in mortality rates. Seeley[26] states large babies have a higher death rate. Our findings indicate that the highest death rates occurred in small babies (5 lbs. 8 oz. to 5 lbs. 15 oz.) The mortality rate for both series was 12 per cent, and in the exceedingly large babies (9 pounds and over) the mortality rate was 20 per cent. We found our best rate was obtained in babies weighing 6 to 7 pounds. This is in accord with other authors. See table 5. (3) For many years labor was thought to be prolonged in breech presentation, however, there are several reports in the literature; Meyer,[19] Ware,[35] Trites,[27] and Gibson[10] which indicate that the length of labor is *not* prolonged in breech presentation. Average length of labor in our series was 13.2 hours for primiparas, and 10.1 hours for multiparas. (4) Maternal morbidity was increased in breech presentation to 7.2 per cent, double that of vertex presentation. No maternal mortality developed in either series.

TABLE 5

MORTALITY RATES AND BIRTH WEIGHTS

	5 lbs. 8 oz. to 5 lbs. 15 oz.	6 lbs. to 6 lbs. 15 oz.	7 lbs. to 7 lbs. 15 oz.	8 lbs. to 8 lbs. 15 oz.	9 lbs. and over
Primiparas	12.0%	3.9%	5.5%	2.2%	12.5%
Multiparas	12.5%	3.6%	6.1%	5.8%	25%
All Cases	12.1%	3.7%	5.8%	4.1%	20%

TREATMENT

It has been our practice in both series of cases to adopt a policy of nonintervention in breech presentation. Most deliveries could be classified as a "spontaneous breech delivery with manual assistance". We feel that deep episiotomy is necessary in the management of breech deliveries. The use of the after-coming head forceps is encouraged. Only one attempt is made to deliver the after-coming head by one of the various maneuvers, failing delivery by this means, the after-coming head forceps are applied. Use of this head forceps was greatly increased in the second group of cases. The rate was 42 per cent as compared to 23 per cent in the first group of cases. The common errors that we observed in teaching the resident staff and while assisting staff physicians were: (1) a tendency to too early interference on the part of the physician, (2) forgetting the axis of the birth canal, (3) attempting to deliver the shoulders before the angle of the scapula was showing and (4) too rapid delivery of the after-coming head.

One of the oldest procedures in the management of breech deliveries might well be re-

examined. I refer to the more routine use of external version. Newell[20] has reported a decrease in the incidence of breech from 3.7 to 2.3 per cent following the institution of routine external version. He further states that external version will reduce by more than 38 per cent the incidence of breech presentation. Certain dangers have been adequately described following external version, notably premature separation of the placenta, prolapse of the cord, and a tendency to reconversion in a few cases.[4] If external version is used, it probably should be done without anesthesia and during the 32d to the 36th weeks of pregnancy with a careful check of the fetal heart sounds during the manipulations. It has not been our policy to practice routine external version in breech presentation, but we feel that such a procedure could well be established with beneficial results in some cases.

One of the principal ways to lower fetal mortality (according to Guyer and Heaton[14]) is by recognizing early, cases showing moderate degrees of pelvic disproportion and more frequent use of caesarian section. In our first series of cases, the incidence of sections was 3.3 per cent while in the second series of cases it was 2 per cent. There were six caesarian sections in the last series and four in the first series. Breech presentation in itself was not an indication for caesarian section in our clinic. Other factors such as elderly primipara, obvious disproportion, unripe cervix, and a large baby were given as indications for these series of sections. No fetal or maternal mortality was associated with these sections.

Early breech extraction has been advocated since 1926 as a method of improving fetal mortality in breech presentation.[11] As Baer[1] asks if an experienced group of specialists cannot avoid such a large increase in fetal mortality accompanying breech extractions how can we justify a recommendation for routine breech extraction? We feel along with Hansen[16] that "if conservatism is good procedure in cephalic presentation, it should be rational in the breech".

The incidence of extractions was low in both series of cases and the main indication for breech extraction in both series of cases was prolapse of the umbilical cord. The fetal mortality was high in both series.

SUMMARY

1. Fetal mortality in breech presentations is greater than in vertex presentation.

2. The maternal mortality is not greatly increased in breech presentations, but maternal morbidity is twice that of vertex presentations.

3. The high gross fetal mortality is primarily due to the very premature fetus with severe malformations.

4. Birth weight is an important factor in breech deliveries. Larger babies have less chance of survival.

5. Prolapsed cord in our series had a fetal mortality of 14 per cent.

6. Labor is not unduly prolonged in breech presentation.

7. By following the conservative management of breech deliveries, with more careful supervision of resident staff and better care of premature babies, we were able to reduce our *gross* fetal mortality from 8.5 to 5.3 per cent, and our *corrected* fetal mortality from 7.3 to 3.4 per cent.

8. Further reduction in mortality rates may be possible by more use of external version in selected cases, caesarian section when indicated, and better care of prematures.

Acknowledgment is made to Drs. Lovett, Rude, Foster and Haines for their valuable aid in reviewing these series of cases. Acknowledgment is made to Dr. George B. German for technical assistance.

429 Cooper Street

DISCUSSION

Robert A. MacKenzie, M.D. (Asbury Park): The Cooper Hospital in Camden has long been recognized far beyond the borders of New Jersey for its fine accomplishment in conservative obstetrical practice, for its leadership in teaching including a resident training program, and for the enthusiastic participation of the staff in every maternal welfare activity. The paper presented by Dr. Johnson is an example of the critical review to which every aspect of their work is subjected by the doctors them-

selves as they strive for perfection. It is an example which every hospital may well follow. Obstetrics lends itself peculiarly well to statistical analysis and much good comes from comparative studies. For comparison, however, there must be uniformity of method and collected figures of breech deliveries should be divided as Dr. Johnson has done, to consider results in pregnancies at or near term separately from premature births.

Breech presentations at term present several special problems. (1) In primigravidae, dilation of the cervix and therefore the length of labor is usually protracted. Other observers do not bear out the encouraging figures reported today which show labor of normal duration. (2) There is increased danger of intra-uterine fetal death during the first stage of labor. Cord pressure can result from occult prolapsus not to be palpated even by vaginal examination. Compression of the cord is not to be expected unless there has been escape of amniotic fluid but premature rupture of the membranes is almost the rule rather than the exception in these cases. In my belief, intracranial damage can result from the force of the contracting uterus upon the fetal head, depending on whether or not the placenta is implanted in the fundus to serve as a protection for the head. (3) Technical difficulty of delivery of the arms and of the after-coming head requires special skill and may be impossible to accomplish successfully if there is fetopelvic disproportion or a pelvic malformation even to the degree that could be readily overcome by moulding of the head in a cephalic presentation.

Dr. Johnson has urged the conservative management of labor including the principle of non-interference in the expulsive phase as long as progress can be observed. I endorse this and recognize the advantages of the Piper forceps to assist extraction of the after-coming head. Anesthesia has not been discussed and there should be mention of the great value of pudendal block in these cases. But ideal management of labor does not completely solve the problem because the fetal loss is still too great. I cannot subscribe to the suggestion offered by Dr. Johnson that external version between the 32d and 36th weeks of pregnancy offers a possible improvement in results. I do not feel that he is convinced. Without a record of successful personal use, I frankly feel he should not advocate this measure. For successful use of external version, the requirements are: preliminary x-ray to make certain of the breech presentation, later x-rays to check the result of the maneuver, relaxation of the abdominal wall, considerable skill and patience in the maneuver itself. To all of this, the young expectant mother may react most unfavorably and whatever might be gained with respect to the position of the fetus could be outweighed by the increased apprehension and excitement as labor nears. Cases of spontaneous version in the last months of pregnancy are not unusual.

In my belief, the greatest difficulties in cases of breech presentation arise from (1) late diagnosis, (2) inaccurate estimation of pelvic architecture and measurements, (3) failure to appreciate the occasional extraordinarily large baby, (4) unnecessary haste in delivery. Fetal loss will be steadily reduced as these four points are eliminated. Roentgenologic study of the pelvis is essential for every patient with a breech presentation at term. Unfortunately, the x-ray is no help as a guide to the size of the fetus in this presentation. One must rely on clinical judgment and this is fallible. It must be remembered that there is no test of labor in breech presentation. Decision to deliver a patient through the natural passage or to perform cesarean section should be made early in labor or before labor with the usual consideration of age, previous infertility, and so forth, aiding the obstetrician's judgment. (A "meeting of minds" is most helpful and consultation as to procedure is valuable between colleagues of equal experience and accomplishment as well as between tyro and a consultant.) The decision to perform a cesarean is often swayed by an early rupture of the membranes and determination of a rigid, closed cervix. I have no fear that one low segment cesarean section necessitates future deliveries by the same operative means.

In the *procedures* set up by the Maternal Welfare Committee of this Society, consultation is urged in primiparous patients with breech presentations. But it is difficult for a consultant to chose between cesarean section and the alternative course of continued labor and delivery in the care of an inexperienced practitioner. This is a delicate situation. A consulting obstetrician should be invited to accomplish the delivery by whatever means he deems best. In all hospitals it would be well to emulate the practice of examples set by Cooper Hospital as mentioned by Dr. Johnson—having a member of the attending staff present for all breech deliveries.

Bibliography will appear in author's reprints.

COURSE IN CHEST DISEASES

The American College of Chest Physicians will sponsor a graduate course in *Recent Advances in Diseases of the Chest*, at the Hotel New Yorker, New York City, November 13 to 18, 1950.

Tuition is $50. Applications will be accepted in the order in which they are received as registration will be limited.

Address all inquiries and applications to the Council on Postgraduate Medical Education, 500 North Dearborn Street, Chicago 10, Illinois.

REMOVAL OF INTRA-OCULAR FOREIGN BODIES BY THE ANTERIOR AND POSTERIOR ROUTES*

A. RUSSELL SHERMAN, M.D., Newark, N. J.

There is difference of opinion sometimes as to whether an intra-ocular foreign body should be removed by the anterior or the posterior route. With this question in mind, a review has been made of the records of 115 patients from whose eyes intra-ocular foreign bodies have been removed: 96 by me and 19 by Dr. Elbert S. Sherman. With few exceptions these are patients who have been operated on since an earlier series, reported in 1939 by Elbert S. Sherman.[1]

Of these 115 foreign bodies, 18 have been omitted from consideration because, though actually intra-ocular, they were in the anterior chamber or iris, so that the question of removing them by the anterior or posterior route did not arise. For the same reason, 8 which were in the lens have been omitted, together with 11, which had damaged the eye so severely that neither method of removal could have been expected to restore useful vision. Of these, 2 had visible pre-operative detachments of the retina, 4 had severe pre-operative infections, and 5 had foreign bodies ranging in size from 3 by 6 millimeters to 5 by 12 millimeters. Seventy-eight remain, whose injuries were such that one might possibly have anticipated a favorable outcome. Of these, 37 were removed by the anterior, and 41 by the posterior route.

OPERATIVE TECHNIC

In using the *anterior* route, the common procedure was to bring the foreign body into the upper part of the anterior chamber, and through a keratome incision above. Occasionally it was possible to draw the foreign body through the corneal wound. The foreign body was always brought to the site of the keratome incision before opening the anterior chamber. This was to minimize the possibility of lens or iris injury likely to occur in maneuvering a foreign body with the anterior chamber collapsed.

In using the *posterior* route, a meridional incision under a conjunctival flap was made with a Graefe knife between two pre-placed scleral sutures. If the foreign body was sufficiently far forward, as indicated by x-ray (or preferably the Berman locator) the incision was made as nearly over the foreign body as possible; if not, the foreign body was drawn forward to the region of the ora serrata. The incision extended only through the sclera, and the foreign body was drawn through the soft tissues by the magnet while an assistant spread the lips of the scleral wound by traction on the sutures. After extraction of the foreign body, the choroid was touched with a hot squint hook, and the sutures tied.

The foreign body was extracted with the hand magnet if possible. The giant magnet was used only if the hand magnet would not move the foreign body. Probe pointed tips were not used because of the relatively weak pull at the end of the probe point, compared with the blunt tip.

RESULTS

The resulting visual acuity and the period of observation in the cases under consideration are shown in table 1.

TABLE 1

Visual Acuity	Route	1 Mo. or less	1 to 6 Mo.	6 Mo. to 1 Yr.	Over 1 Yr.	Total
20/30 or better	A	1	2	.	5	8
	P	5	10	5	5	25
20/40 to 20/70	A	.	1	2	3	6
	P	3	1	1	2	7
20/80 to 20/200	A	1	1	2	1	5
	P	.	.		1	1
No useful vision	A	2	6	4	6	18
	P	1	2	5	.	8
Total		13	23	19	23	78

1. Visual acuity after removal of foreign body. Route of removal is indicated as A or P—anterior of posterior. Time indicates period of observation in months.

* Read by invitation before the 184th Annual Meeting of The Medical Society of New Jersey at Atlantic City on May 22, 1950.

1. Sherman, E. S.: American Journal of Ophthalmology, 22:1368 (December 1939).

In cases with no useful vision following operation, the causes of poor vision were as follows: (Table 2)

TABLE 2

	Ant.	Post.	Total
Iridocyclitis	8	2	10
Unoperated cataract	7	1	8
Hemorrh. in the vitreous	2	2	4
Detachment of retina	1	3	4
Total	18	8	26

2. Causes of visual impairment in the 26 eyes left with no useful vision following operation.

Two of the retinal detachments following removal by the posterior route were probably pre-existing, since there was faulty light projection before operation.

MODIFYING FACTORS

The records were further studied to determine the possible effect on the final visual acuity of the following: (1) size of the foreign body, (2) visual impairment before removal of the foreign body, (3) point of entrance of the foreign body.

Any foreign body measuring 3 millimeters or longer was considered "large". There were 23 of these; twelve had been removed by the anterior, and eleven by the posterior route, a difference not great enough to be significant.

To investigate the effect of pre-operative visual impairment, the number of the eyes with no useful vision before operation was compared with those having no useful vision after operation. (See table 3.)

TABLE 3

	Ant.	Post.
Poor vision before	14	11
Poor vision after	18	8

3. Eyes with no useful vision before and after operation.

Of the 18 with no useful vision after operation by the anterior route, only 9 had none before operation. Of the 8 with no useful vision after operation by the posterior route, 7 had none before operation. The markedly more successful results following removal by the posterior route cannot, therefore, be attributed to less visual impairment before operation.

In general, foreign bodies which had injured the lens were more frequently removed by the anterior route. Hence, it is not surprising that a tabulation based on the path of the foreign body shows lens injury in almost 3 times as many cases removed by the anterior route as by the posterior route. (Table 4)

TABLE 4

Path of foreign body	Ant.	Post.
Behind ciliary body	3	7
Thro' or ant. to ciliary body	34	33
Thro' lens	25	9

4. Path of the foreign body classed according to route of extraction.

These figures suggest that the path of *entrance* rather than the path of *exit* of the foreign body may explain the relatively poor results of extraction by the anterior route; but lens injury is sometimes caused by the exit of a foreign body rather than by its entrance. In at least one case, a lens, previously clear, was perforated by an emerging foreign body. In another, cataract followed iritis and severe anterior chamber hemorrhage after extraction by the anterior route of a foreign body which had entered posteriorly.

Of the seven cases in which the foreign body entered behind the ciliary region and was removed behind the ciliary region, all had a good surgical result, and six had a visual acuity of 20/30 or better.

CONCLUSIONS

When the results are condensed and expressed in percentages, it is found that loss of useful vision occurred in 50 per cent of cases following removal by the *anterior* route; in 20 per cent by the *posterior;* vision of 20/70 or better resulted in 38 per cent following removal by the *anterior* route; in 78 per cent by the *posterior.*

Unless one chooses to attribute to preoperative lens injury the markedly poorer outcome of operations by the anterior route, these results leave scarcely any question as to the superiority of the posterior method. It has been already pointed out that operation an-

teriorly can cause cataract and iris hemorrhage. In addition, traction on the iris, sometimes severe and repeated, is often necessary to disentangle a foreign body. It is reasonable to attribute iridocyclitis to this traction in occasional cases.

In two cases (not included in this series) of attempted removal by the anterior route, a minute foreign body was brought forward as far as the ciliary region and became so entangled that it could never be removed.

If the posterior route is used, none of these complications can occur. If the foreign body is embedded in the retina anywhere except in the very posterior portion, it can be localized with the Berman locator and removed at the site with minimum trauma. For such foreign bodies this is definitely the procedure of choice. In certain other cases the foreign body can be brought to the region of the ora and extracted through an incision accurately placed by the help of the locator.

Probability of causing detachment of the retina is sometimes offered as an objection to extraction of a foreign body posteriorly. There is but one case in this series in which detachment of the retina can be attributed to extraction by the posterior route. This occurred in 1943. The foreign body had lodged in the retina 6 disc diameters below and temporal to the disc. It was pulled forward to the ora serrata for removal. Two days later a retinal tear was observed between the original site of the foreign body and the site of its removal, and was followed in a few days by a detachment. If the Berman locator had been available, the foreign body could have been removed through an incision placed directly over it in the sclera, possibly without causing a detachment. That this is not too far back for direct removal of a foreign body is demonstrated by another case in which the foreign body lay only 3 disc diameters below the disc, and was successfully removed through an incision slightly behind and below the insertion of the inferior oblique muscle, this position having been indicated by the Berman locator.

Most foreign bodies travelling with sufficient force to penetrate the outer coat of the eye do not stop until they have become embedded in the retina. It would seem that such a foreign body being drawn forward for removal by the anterior route might well (if it had rough edges) draw the retina with it, and that the possibility of causing a retinal detachment is not limited to operation by the posterior route.

In recent injuries, when it is desirable to remove the foreign body promptly, a possible objection to operation by the posterior route is the delay in obtaining a localizing x-ray examination amounting, usually, to 24 to 48 hours. In many cases, however, this objection does not apply, since the foreign body can be located more accurately with the locator. An ordinary x-ray examination to show the size and shape of the foreign body is desirable; but this is unnecessary if the foreign body can be seen with the ophthalmoscope.

In the present group 20 (25 per cent) of the foreign bodies were seen with the ophthalmoscope. The combination of examining and localizing the foreign body in the interior of the eye with the ophthalmoscope, and localizing it externally with the Berman locator is practically ideal.

The anterior method should be first choice only when there is some obvious reason such as a large wound in the anterior part of the eye. For other cases, the first thought should be how best to remove the foreign body posteriorly especially if a Berman locator is available.

In cases, before 1944, 55 per cent of the foreign bodies were removed by the anterior route; since then, this method has been used in only 39 per cent, because of increased accuracy and safety resulting from use of the locator in posterior extraction.

671 Broad Street

TREATMENT OF RHEUMATOID ARTHRITIS WITH PREGNENOLONE*

JOHN A. STRAZZA, JR., M.D., Bloomfield, N. J.

For the past decade, numerous steroid substances including hormones and vitamins, have been reported to be of value in treatment of arthritis. Among the steroids so reported are progesterone,[1] estradiol,[2] testosterone, desoxycorticosterone, cortical extract,[3] and ergosterol.[4] These steroid substances in varying combinations and together with gold constituted the routine therapeutic armamentarium in rheumatoid arthritis until early in 1949, when Hench and others[5] reported the value of cortisone and ACTH in this form of arthritis.

Inadequacy of the supply of cortisone and ACTH has led to a search among the more abundant steroids for remedies of equal value and of less toxicity. Although cortisone and ACTH give a high incidence of remissions and prompt effects, side reactions and costs preclude their general use. Among these toxic effects are severe adrenal stimulation leading to hypertrophy, Cushing's syndrome, insomnia, hirsutism, acne, amenorrhea, edema with sodium retention and potassium loss, negative nitrogen balance, altered serum albumin-globulin ratio, changes in erythrocyte, leucocyte, lymphocyte, eosinophile and neutrophile counts and in hemoglobin, impaired tissue repair and psychic changes varying from euphoria to mild depression, and even psychotic reactions, when the patient finds his initial temporary improvement followed by exacerbation of his arthritis.

Massive doses of estradiol, progesterone, testosterone and desoxycorticosterone over considerable periods produce undesired effects. Selection, therefore, was made of pregnenolone* from among the available steroids of known low toxicity. In mice, a single dose of 5 Grams per kilogram of body weight caused no symptoms. Subcutaneous daily dosage of 10 milligrams per kilogram for three months caused no change in visceral weights in rats. Intraperitoneal dosage of 200 milligrams per kilogram, three times weekly for four months led to no change in red blood cells, hemoglobin, white cell count or visceral weight in rats.[6] Clinical doses as high as 300 milligrams per day have been given intramuscularly for six months with no toxic or untoward reaction.

Because of its low toxicity, this steroid was employed in therapy of 22 rheumatoid arthritics, 4 males and 18 females, between the ages 23 and 79. Duration of the disease varied from two months to 23 years. Excellent results were achieved in 16 of these 22 patients and good results in four.

MATERIAL AND PROCEDURE

Of the 22 cases of rheumatoid arthritis 4 were of the Marie-Strümpell type. Complete history was taken and physical examination done for each patient. Routine monthly laboratory examinations consisted of urine analysis, complete blood count including blood smears, nonprotein nitrogen, blood sugar, sedimentation rates, chest x-ray, electrocardiograms and x-ray examinations of the affected joints. Serum calcium and potassium were determined in four patients. Weights were recorded every two weeks. Registered nurses from the Visiting Nurses Service of the patients' communities administered the injections between weekly office visits. Motion pictures[7] of ten patients were taken before and after treatment. Four typical case histories are detailed below.

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* Pregnenolone is a synthetic steroid. The drug used in this project was "Prenolon", the Schering Corporation brand of pregnenolone. It was supplied through the courtesy of Dr. W. H. Stoner of the Schering Corporation, Bloomfield, N. J.

1. Hench, P. S.: Proceedings of the Staff of the Mayo Clinic, 13:161 (1938); *also,* Barsi, I.: British Medical Journal, 2:252 (1947) *and,* Reich, N.: American Practitioner, 4:1 (January 1949).
2. Cohen, A., Dubbs, A. W., and Myers, A.: New England Journal of Medicine, 222:140 (February 1940); *also* Hall, F. C.: New England Journal of Medicine, 219:1015 (June 1938).
3. Watson, E. W.: Endocrinology, 27:521 (May 1940); *also,* Lyon, E.: Acta Medica Orientalica, 4:219 (March 1945), abstracted in the Journal of the American Medical Association, 129:837 (November 1945).
4. Dreyer, I., and Reed, C.: Archives of Physical Therapy, 16:537 (April 1935).
5. Hench, P. S. *et al.*: Proceedings of the Staff of the Mayo Clinic, 24:181 (1949); *and* Boland, E. W., and Headley, N. E.: Journal of the American Medical Association, 141:301 (October 1949); *and* Regan C., Grokoest, A., and Boots, R.: American Journal of Medicine, 7:241 (February 1949).
6. Tislow, R.: Personal Communication to the author.
7. Strazza, John A., Jr.: Paper on the treatment of rheumatoid arthritis with pregnenolone presented, by invitation, to the Academy of Medicine of Northern New Jersey, in Newark, N. J., on May 18, 1950.

CASE ONE

Housewife, age 56. Rheumatoid arthritis of nine years' duration involving ankles, knees, hips, low back, neck, shoulders, elbows, wrists and hands. She had constant pain, and was unable to straighten her knees for last four years. Diabetes mellitus was found in 1937, but controlled by diet. Previous treatment consisted of hot baths, massage, salicylates, vaccines, sulphur baths and gold.

Examination: An obese woman, chronically ill, unable to walk without assistance and cane. Blood pressure was 105/75. Palpation and passive motion caused pain in the neck, shoulders, elbows, wrists, fingers, hips, knees and ankles. Her knees were swollen and inflamed and could not be fully extended. She had spasticity of the neck and upper back.

Laboratory data: Except for a trace of sugar, urine analysis was negative. Hemoglobin was 80 per cent. The red and white cell counts were 4,800,000 and 8000 respectively. Of the leucocytes, 64 per cent were polymorphonuclears and 31 per cent were lymphocytes. Monocytes, basophiles and eosinophiles account for 1, 2 and 2 per cent. Sedimentation rate was 20 millimeters in one hour. Blood sugar was 168 milligrams per cent. The nonprotein nitrogen, calcium and potassium in the blood were 30, 11 and 19 milligrams per cent respectively.

Roentgen findings: Advanced arthritic changes of atrophic type were seen in the hands, elbows and knees. There was almost complete obliteration of the joint spaces of the knees.

Treatment and results: Daily intramuscular injections of pregnenolone (350 milligrams) were instituted. Within one week she showed marked improvement. There was considerably less swelling of the knees. Pain was greatly diminished and there was increased motion. After three weeks she could straighten her knees and walk without assistance of any kind and had no pain in any joint. She is still under therapy, 350 milligrams every other day. Recent examinations of blood, urine and electrocardiograms have revealed no abnormalities. There has been no material change in the sedimentation rate.

CASE TWO

Female, age 71. Chronic rheumatoid arthritis for 20 years with acute exacerbation especially in hands and knees. The present acute attack began two months prior to therapy and involved both knees. Previous treatment consisted of bed rest, continuous warm saline dressings, salicylates and massage.

Examination: This acutely ill patient had to be assisted in walking by two persons. Heart was enlarged to the left. A loud systolic murmur was audible over the entire precordium, most intense at apex. The liver was two finger-breadths below the costal border. She showed mild pitting edema of both ankles. Both knees were swollen, warm and very painful on even slight palpation and motion. Blood pressure was 200/100.

Laboratory data: Blood studies revealed the following: hemoglobin was 80 per cent; red cells were 4,000,000; leucocytes numbered 7600, but only 57 per cent were polymorphonuclears. Lymphocyte ratio was 38 per cent, monocytes 2 per cent, eosinophiles two per cent and basophiles one per cent. Sedimentation rate was 22 millimeters in an hour. Nonprotein nitrogen was 34 and blood sugar 88 milligrams per cent.

Roentgen data: Cardiac x-ray showed a hypertensive arteriosclerotic heart with an enlarged left ventricle. The knees showed atrophic arthritis, changes in both joints, swelling of the soft tissue and narrowing of the joint spaces.

Treatment and results: Pregnenolone was given intramuscularly, 350 milligrams a day. Within one week, swelling of the knees was greatly diminished, pain almost completely gone and she could walk without assistance. After two weeks of therapy, her knees appeared normal and she was asymptomatic. She has been maintained on two injections a week of 350 milligrams each. Repeated examinations of blood, urine and electrocardiograms have revealed no abnormalities. Sedimentation rate has not changed significantly.

CASE THREE

Female, age 45. Advanced rheumatoid arthritis of 12 years' duration involving all the joints of the body. She had been confined to bed for the past two years. Previous treatment had consisted of salicylates, gold and typhoid vaccine.

Examination: A chronically ill patient confined to bed. Blood pressure was 150/90. She was unable to move any part of her body without severe pain. She was unable to move her head. Her neck was stiff. Muscles of neck and upper back were spastic. She could move her arms about an inch without pain. Her fingers and knees were swollen. She had to be fed, took large quantities of whiskey and aspirin to relieve pain. She was extremely irritable.

Laboratory data: Hemoglobin and red cell count were normal and the leucocyte tally was 7700. However only 60 per cent of these were polymorphonuclears. Basophile numbered 1 per cent, eosinophiles 3 per cent, monocytes 2 per cent, while the remaining 34 per cent were lymphocytes. Nonprotein nitrogen was 32.4. Blood sugar was only 76 milligrams per cent. Sedimentation rate was 24 millimeters in 30 minutes.

Treatment and results: During the first six weeks, we administered 300 milligrams of pregnenolone every day by intramuscular injection. We then gave injections every second day, maintaining the dose at 300 milligrams per injection. Within two weeks of the first treatment, she reported marked improvement and there was visible decrease in swelling and increase in the range of motion. After one month, she was up in a wheel chair and could be transported for examination and treatment. She is now able to feed herself and can straighten her back and move her head from side to side without pain. Improvement in personality was remarkable. Repeated laboratory studies revealed no abnormalities or untoward reaction from therapy. Sedimentation rate was not significantly changed.

CASE FOUR

Female, age 73. Rheumatoid arthritis of two years' duration involving the shoulders, hands and

especially knees. Previous treatment consisted of baths, massage, salicylates and injections of snake venom.

Examination: A chronically ill patient with definite limitation of motion of arms. She could touch her head only with great effort and pain. Both knees were swollen and very painful on motion. A cane was necessary for walking. Blood pressure was 180/100.

Roentgen data: Advanced atrophic changes were visible throughout the joints of both knees and all fingers. There was marked decrease in joint spaces of the knees.

Laboratory data: Electrocardiogram revealed left axis deviation. Blood sugar was only 69.4 milligrams per cent, nonprotein nitrogen was 28, calcium 10.5 and potassium 18 milligrams per cent. Sedimentation was 24 millimeters in thirty minutes. Hemoglobin was 75 per cent. The red and white cell counts were 3,400,000 and 7700 respectively. Differential blood smear showed only 58 per cent polymorphonuclear leucocytes, with lymphocytes accounting for 36 per cent, monocytes for 3, basophiles for 2 and eosinophiles for one per cent.

Treatment and results: For two months she received daily intramuscular injections of pregnenolone, dosage being 350 milligrams. After one week, pain was greatly diminished and motion much improved. She could raise her arms over her head, make a fist and walk better. The shoulder pain was completely gone. Because of persistence of slight swelling and pain in left knee, intensive therapy was continued for two months before subsidence of swelling and relief of pain were complete. At present, she is maintained in comfort with three injections of 350 milligrams a week. Repeated laboratory tests show no abnormalities or toxic effects. Sedimentation rate showed no material change.

COMMENT

This clinical study furnishes further evidence that pregnenolone* profoundly modifies the course of rheumatoid arthritis in all stages. The mechanism of action of pregenolone* is not known. However, its action affords a clue to the pathogenesis of this disease. Further trials and observations are indicated. It was found from this study that dosage varies with individual patients but that 350 to 400 milligrams daily were necessary, initially, to achieve the desired results. After remissions occurred, most patients could be maintained on slightly lower doses of 300 milligrams once or twice weekly. A few patients require 350 milligrams two or even three times a week. Two patients who had received adequate therapy with complete relief of symptoms, discontinued pregnenolone* with a return of symptoms after about 25 days. These patients were again given large doses with complete control of symptoms. A few patients responded favorably after the first few injections. Others responded to one, two or three weeks' treatment. In some, improvement was dramatic except for one joint, usually a knee, which would respond slowly. Even this would usually yield after a period of weeks. In all patients there was a definite relief of spasticity with resultant decrease or disappearance of pain and increase in motion. Age appeared to be no factor in response. The degree of arthritic changes (except for permanent and marked deformities) and the duration of the disease were also of no aid in prognosis. Far advanced cases showed as rapid and marked improvement as the relatively early cases. However, in general, it could be predicted that in early cases, without bone changes but with swelling of soft tissue the patient would have normal joints after response to therapy. Those with bony destruction would not.

Repeated laboratory studies revealed no abnormal changes attributed to pregnenolone.* Early in this study, pregnenolone was used as an aqueous suspension and later as a solution in 50 per cent benzyl alcohol and 50 per cent sesame oil. The latter preparation in some cases caused swelling at the site of injection with little inflammation or pain. In no instance was there any destruction of tissue. The cause was probably the solvent rather than the steroid.

One very interesting observation was the dramatic change in personality of many of these patients. Before therapy some accepted their disease stoically, others were so moody and complained so bitterly that their entire families were as depressed as the patients. With response to therapy, depression disappeared rapidly and they began to act like normal, social human beings again. Husbands and wives of the patients were especially thankful for the personality changes. Improvement of bedridden patients, sufficient to get them into wheelchairs and able to help themselves, lifted a heavy burden from other members of the family. It was gratifying to see patients, who before treatment could walk only with assistance, crutches or cane, with con-

siderable pain and flexed knees, after a few weeks, walk without pain and with knees in full extension. One woman was made happy because, following treatment, she could do her housework and even play the piano for the first time in years. Greatest personality improvement was experienced by those who could return to gainful employment. However, there were a few who, even after marked improvement, continued to complain about the residual minimal disability just as bitterly as if there had been no improvement. It seemed to be impossible for this group to remember their condition before therapy. Most of the patients complained about the necessity for continuing maintenance therapy.

183 Broad Street

SUMMARY

1. Twenty-two cases of rheumatoid arthritis (4 of Marie-Strümpell type) were treated with pregnenolone* without collateral antirheumatic therapy of any kind.

2. Excellent results were obtained in 16, good in 4 and poor in 2 cases. The two failures were very advanced cases of Marie-Strümpell type.

3. Pregnenolone* is non-toxic in large doses and readily available at moderate cost.

4. These clinical results show that pregnenelone* given in large doses and for sufficient length of time is a highly effective therapeutic agent in the treatment of rheumatoid arthritis.

TREATMENT OF RHEUMATOID ARTHRITIS BY THE GENERAL PRACTITIONER*

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In evaluating any method for the treatment of arthritis, we must ask ourselves just what the modality is expected to do. Will it:

1. Stop the progress of the disease? or
2. Reverse the progress and repair damage already done? or
3. Exercise some good or deleterious effect on the entire body both in immediate and long range terms?

These points are of paramount importance, since arthritis is reversible[1] up to a certain point. Furthermore, this disease shows spontaneous remissions and exacerbations. In evaluating a response to a therapy, it is desirable to follow the criteria established by Steinbrocker *et al.*[2] for the American Rheumatism Association. These criteria include functional, objective and laboratory changes. A sufficient number of cases must be studied under these criteria before conclusions can be drawn. We must travel on a sound road in appraising therapy. It is easy to fall by the wayside with the many therapies of the past that had a quick ascension to stardom and soon fell into disrepute.

MEASURES OF PROVED VALUE

1. *Cortisone and ACTH*—Any discussion of rheumatoid arthritis must start with the monumental work of Hench[3] and his coworkers in the discovery of the dramatic improvement obtained with Compound E (17 hydroxy 11 dehydrocorticosterone) or Cortisone† as it now is known, and with ACTH (adrenocorticotrophic hormone). Those of us who have used these drugs, know how remarkable and gratifying the results have been. However, to maintain the effects, continued use over long periods of time is required.[4] Further metabolic studies[5] are needed to determine the side effects, which in the main have

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* Read by invitation at the Annual Meeting of The Medical Society of New Jersey, May 24, 1950.

† Distributed by Merck and Company, Rahway, N. J.

1. Hench, P. S.: Proceedings, Mayo Clinic, 24:167 (1949).
2. Steinbrocker, O., Traeger, C. H., Batterman, R. C.: Journal of the American Medical Association, 140:659 (June 1949).
3. Hench, P. S., Kendall, E. C., Slocumb, C. H., and Polley, H. F.: Proceedings, Mayo Clinic, 24:181 (1949).
4. Hench, P. S., Kendall, E. C., Slocumb, C. H., and Polley, H. F.: Archives of Internal Medicine, 85:545 (April 1950).
5. Sprague, R. G., Power, M. N., Mason, H. L., Albert, A., Mathieson, D. R., Hench, P. S., Kendall, E. C., Slocumb, C. H., Polley, H. F.: Archives of Internal Medicine, 85:199 (February 1950).

been reversible, and to effect a standardization of dosage.

A new field of steroid chemistry is on the horizon, as documented by Mote[6] and others, which permits the hope that in the not too distant future, many new preparations of low or no toxicity will be available. Perhaps an oral drug will replace the "needle" industry. Let us hope the cost will be low enough for general use.

2. *Rest of the body and involved joints and exercise*—This includes physical, physiologic and mental rest. Picture the attitude of a breadwinner who has been ill for two or three months and sees the possibility of crippling in the future. This patient must be reassured and told that with proper rest and therapy his chance of becoming a useful member of society again is excellent. It may be necessary to call a family conference or have an agency provide financial aid during this unfortunate period, should the need appear. When these means are found, the emotional solace to the patient will greatly aid in his rehabilitation. Re-education of the family attitude toward the already crippled is of utmost importance, and may prevent a catastrophe. *It is never necessary to prescribe absolute bed rest.*[7] Body rest and specific joint rest must be supervised by the attending physician. A picture too well known to all of us is that of the patient in bed with pillows under flexed knees. This is worse than no rest at all, for should the knees ankylose in the flexed position, standing or walking will be impossible. Ragan[8] states the ideal is rest coupled with exercise, but this must be prescribed very judiciously. An inflamed joint should be placed at rest or even in a plaster cast in the best possible physiologic position. As inflammation subsides, the cast should be removed several times a day and the joint taken passively through its full range of motion. Somewhat later, exercise can be started up to the amber signal light, which is moderate pain. When active motion causes an abnormal amount of pain, you are irritating a still inflamed joint. You are going through the red signal light and can cause irreversible joint damage. Many a patient has done this to himself because of the fallacious belief that if "I don't keep moving I'll stiffen up". This fallacy has destroyed more knee joints than anything else.

Increasing periods of activity from bed rest can be accomplished by the orthopedic measures reviewed below. This increase should be guided not only by the patient's subjective statements, but also by objective evidence of subsidence of swelling, redness, sedimentation rate and temperature.

Rest for the patient should be made as pleasant as possible, with proper bed rests or couches. Cheerful rooms with sunlit surroundings, radio or a television set will make time pass more quickly and keep the patient happy.

3. *Physical therapy* is important and can be accomplished simply at home without expensive gadgets. Heat to an affected part will be helpful and can be maintained by a hot water bag, electric pad or a radiant lamp. Often, paraffin baths or painting with paraffin will help soothe a painful joint. This is comparatively inexpensive. Some member of the family can be taught massage, which should be applied lightly, after heat, as a preliminary to active motion. Massage will often prevent massive muscle atrophy.

Short wave diathermy should not be used during the acute phase of rheumatoid arthritis. This modality increases osteoporosis and does more damage than good. It has some place in the treatment of more advanced and quiescent phases of the disease. Ultra-violet light has questionable value. One practitioner told me, he gives it to all his patients, because it makes them look "healthy". Galvanic current and iontophoresis with various medicaments such as histamine, are soothing and helpful, as is sinusoidal stimulation of muscles. But these highly specialized and expensive technics are often unnecessary. Occupational therapy may be a great aid in awakening a patient's interest in exercising important groups of muscles.

4. *Diet*—A normal, sensible, well balanced diet with adequate vitamin and mineral intake

6. Mote, J. F.: *Proceedings of the First Clinical ACTH Conference.* Published by Blakiston Co., 1950, Philadelphia.
7. *Primer on the Rheumatic Diseases.* Prepared by The American Rheumatism Association. Published by the American Medical Association. Pages 34 and 39 (April 1949).
8. Ragan, C.: Journal of the American Medical Association, 141:124 (September 1949).

is the best diet for the rheumatoid patient. Fads in diet are of no known value. In obesity, a low carbohydrate and low fat diet are indicated. Conversely a high caloric diet with vitamins, liver and iron supplements will bolster the malnourished.

5. *Drugs*—Salicylates are as specific for the pains associated with rheumatoid arthritis as penicillin is for pneumonia. Salicylates must be given in adequate doses. Coburn and others have shown that the addition of sodium bicarbonate (although relieving some gastric irritation) does not permit as high a blood salicylate level as when salicylates alone are administered. Acytl salicylic acid (aspirin) is still the drug of my choice when given in doses of at least ½ grain per pound of body weight in 24 hours.* Should this cause toxicity it can be stopped and resumed at lower levels. Enteric coating added to aspirin will help avoid gastric irritation. Barbiturates may be used for rest and sleep. Codeine can and should be used to help a patient through a painful siege. Morphine and meperidine hydrochloride (trademarked as "Demerol") should never be used in such a chronic condition, as addiction will invariably develop. I rarely have need for aminopyrine, neocincophen or cincophen. They are all potentially dangerous drugs. Methyl salicylate (oil of wintergreen) applied locally to an affected joint is extremely helpful. However a word of caution: Taken internally, it is very toxic and can cause death in a short time.

6. *Climatotherapy* — Well controlled studies[9] have not been made on the incidence of rheumatoid arthritis in various parts of the United States or on the effects of climate on the disease once established. We know that cold or sudden changes in temperature are a rheumatoid's enemy. Therefore, he should be very cautious. Rubbers, raincoats, umbrellas and warm clothing are a "must". Sudden chilling may be a factor in inducing Selye's "stress mechanism". Electric blankets and even sleeping gloves are often advised. About 20 per cent of rheumatoid arthritics are greatly benefited by a warm dry climate, when no other measures of treatment are used. The other 80 per cent still need medical care. How many patients can just pick up roots and disrupt their family, economic and social life? The answer is obvious. Therefore, in general, the rheumatoid must learn to live as sensibly as possible in his regular surrundings with a maximum of the comforts available.

7. *Orthopedic Measures*—Braces and supports to affected joints are useful in prevention of further deformity. They can also help repair some of the reversible damage. Elastic bandages to painful knees and lateral steel bars which bend with walking, and prevent lateral motion) maintain many a weak knee joint. Well fitted arches for proper alignment of the feet, and a redistribution of weight are important. Sleeping casts to the hands and wrists to prevent ulnar deviation, can easily be made in the office with the new plastic materials. These will cause the patient no inconvenience and will not interfere with sleep. Braces for the cervical spine and lower back are most helpful.

Orthopedic manipulation under anesthesia and reconstructive surgery of deformed joints are in the province of the orthopedic surgeon.

MEASURES OF PROBABLE VALUE

1. *Fever therapy* induced by typhoid vaccine intravenously, foreign protein or fever machines are still being used to stimulate a severe bodily reaction. I have seen fever therapy stop an acute fulminating process and cause it to become more quiescent. Fever therapy has its dangers as the patient is usually in a debilitated state and the shock to the system can be too great. Thus, a word of caution.

2. *Deep x-ray therapy* is of considerable value in the opinion of Freyberg[9] and others in rheumatoid spondylitis. My own experience with this treatment has been excellent. In peripheral rheumatoid arthitis it is of little or no value. The possibility of adrenal stimulation (when deep x-ray therapy is given over the spine) leads to much speculation.

3. *Removal of foci of infection* is a moot question. We have all lived through the period when patient after patient has had all of his teeth removed and still the crippling progress-

* Thus a man weighing 180 pounds would receive 90 grains of aspirin in 24 hours!

9. Freyberg, R. N.: Special Clinical Conference, Hospital for Special Surgery, New York City (1949).

ed. Removal of obvious foci should be undertaken with the thought of improving the entire body condition and not with the expectation of a specific cure.

4. *Gold therapy* has been in use since the 1920's and its efficacy is still subject to question. Beckman[10] has said: "let's give it up". Yet Rosenberg[11] as recently as July 1949 said, "With few exceptions, experienced American rheumatologists are continuing the use of gold preparations in the belief that results obtained therewith are better than those obtained with any other single remedy". I have seen patients respond to gold therapy when all else failed, and for the present I believe that it still should be used. My own routine is to give 10 milligrams bi-weekly for four doses; then, if tolerated, 25 milligrams weekly until 1500 milligrams are accumulated. The urine must be examined before each injection for red blood cells. If erythrocytes persist in the urine, gold therapy must be stopped. Should stomatitis, pruritis rash or any unusual reaction develop, gold must also be discontinued. We watch the blood count for development of anemia, leucopenia or eosinophilia. These are the danger signals of an impending unfavorable gold reaction. The fear of gold reactions has lessened considerably since we have learned that British Anti-Lewisite‡ is effective for heavy metal toxicity.

5. *Blood transfusions* more than any other of the non-specific modalities, are main standbys. Repeated transfusions at weekly intervals for 6 to 8 weeks have resulted in many spectacular remissions. I feel that early in the disease, multiple transfusions will often cause a complete reversal of the disease. I use this as a non-specific modality. Barsi's work with transfusions of blood from pregnant women has not been confirmed in this country.

‡ Familiarly known as B.A.L.

10. Beckman, N.: *1950 Year Book of Drug Therapy* (Page 447) Year Book Publishers, Chicago (1950).

11. Rosenberg, E. F.: Journal of the American Medical Association, 140:762 (July 1949).

6. *Pregnenolone*—No report at this time would be complete without a mention of Pregnenolone and Progesterone. Unfortunately most of the reports are confusing. Good results varying from 20 to 80 per cent were given at a recent clinical conference on pregnenolone. The results seem to depend on the enthusiasm of the observer. I await more controlled studies before accepting or discarding this procedure in the treatment of rheumatoid arthritis.

The table below represents a compact check list which will assist the practitioners in reviewing possible treatment methods.

Much can be done for almost every rheumatoid sufferer. An optimistic attitude and a good knowledge of the disease will be of help and comfort to every rheumatoid patient. The problem must be approached directly and hopefully and the results will be worth the effort expended.

RHEUMATOID ARTHRITIS:
A THERAPEUTIC CHECK LIST

Seven measures of proved value

1. Cortisone and ACTH
2. Rest and exercises
3. Physical therapy
4. Appropriate diet
5. Climato-therapy
6. Orthopedic measures
7. Salicylates and barbiturates

Six measures of probable value

1. Fever therapy
2. X-ray therapy
3. Removal of foci of infection
4. Gold salts
5. Blood transfusions
6. Pregnenolone and Progesterone

Fourteen measures of questionable value

1. Vaccines
2. Vitamin D
3. Endocrines
4. Iodides
5. Arsenicals
6. Sulfur
7. Bee venom
8. Antireticulocytotoxins
9. Intravenous procaine
10. Spinal "pumping" (Speranky)
11. Foreign protein
12. Chalmoogra oil
13. DCA with vitamin C
14. Prostigmin

Eight methods of no value

1. Splenectomy
2. Dietetic fads
3. Hemicolectomy
4. High colonic irrigations
5. Thyroid surgery
6. Intestinal antiseptics
7. Parathyroidectomy
8. Cobra venom

31 Lincoln Park

HEMATOLOGY: ITS PAST AND FUTURE*

Lowell A. Erf, M.D., Philadelphia, Pa.

The subject, "Recent Advances in Hematology" is most timely because "hematology" has advanced rapidly during the past 25 years.

Hematology consists of the attempted understanding and treatment of the changes from normal, of the formed blood elements, the plasma, and the capillaries. Twenty-five years ago hematology consisted essentially of counting and classifying red cells, white cells and platelets; timing of the coagulation of blood and testing the fragility of capillaries by the tourniquet test, plus an attempt to alter any abnormalities therapeutically. As knowledge for treating hematologic diseases expanded, there was some question (about 15 years ago) whether the specialty of hematology would continue. Nutritionists were treating successfully, many cases of anemias and bleeding dyscrasias with iron, proteins, yeast, liver, vitamin B, vitamin C, vitamin K, et cetera. Endocrinologists were successfully using hormones and enzymes, such as thyroid extracts, placental extracts, estrogens, nucleotides, adrenaline, parathormone, et cetera. Radiologists were moderately successful in treating patients with leukemia and lymphomata with x-rays. Surgeons were treating successfully many patients with purpura, congestive splenomegaly, hemolytic anemia et cetera by splenectomy. So, for awhile, it did seem that hematology as a specialty might disappear, and be absorbed by other specialties. However, hematology, like oncology, is one of the few subjects that "cuts through" every subject in medicine. Blood is the only "floating" tissue and it reaches, modifies and affects (and is affected by) all parts of the body. Nowadays, we have many types of hematologists. We have the *coagulationists* who study only the coagulative mechanisms of blood, the *transfusionists* who only transfuse blood, the *agglutinologists* who study only the typing of blood, the hematologic *morphologist,* the hematologic *geneticist,* the hematologic *immunologist,* the hematologic *radiophysicist,* the hematologic *nutritionist,* the hematologic *surgeon,* the hematologic *toxicologist* to mention only ten varieties of hematologists. Now that cortisone, ACTH and other hormones are available, we probably shall have many types of hematologic endocrinologists in the near future. The surgical aspects (such as portal-caval shunts, artery transplantation, the removal of aneurysms, pulmonary hemangiomata, and areas of teleangiectasia, the ligation of varicose veins, splenectomy, et cetera) have limitless hematologic horizons. The geneticist is explaining many hematologic processes such as congenital hemolytic jaundice, sickle cell anemia, Cooley's anemia, teleangiectasia, hemophilia, purpura, kernicterus, erythroblastosis, and the like. Blood typing has become a major item in understanding transfusion reactions, congenital defects, erythroblastosis, and in establishing paternity, identifying criminals and so forth. The chemists and enzymologists are beginning to explain the composition and uses of heparin, dicumarol,† thromboplastin, fibrinogen, folic acid, vitamin B_{12}, thyroxin, 17 ketosteroids, 11 oxysteroids, phosphatases, hemoglobin, insulin, adrenocortico-trophic hormone, et cetera. The psychiatrist is now explaining how emotions can secondarily cause chemical imbalances which result in various hematologic disturbances. Therefore, it appears that hematology is the broadest of all specialties.

For example, Dr. Konzelmann is going to mention some of the features of immunohematology, such as the numerous antigen-antibody reactions that can occur in the body that result in such widely divergent processes as eosinophilia, periarteritis nodosa, erythroblastosis and so forth. Dr. Moolten is going to discuss at least two hormones: thrombocytosin and thrombocytopen — which affect the quality and quantity of available platelets and which indirectly can cause hemorrhage or thrombosis in any part of the

* Opening remarks at the medicine panel, Annual Meeting of The Medical Society of New Jersey, May 23, 1950. The papers to which Dr. Erf refers have appeared or will appear in this year's issues of this Journal.

† Dicumarol is the collective trade name for methylene hydroxy coumarin registered by the Wisconsin Research Foundation.

body. The occurrence of small cerebral thromboses probably is the most important cause of "senility". Dr. Pons will discuss the broad field of anemia, mentioning the uses of the radioisotopes as means for understanding the causes of some of the anemias and will also discuss sickle cell anemia—the first known molecular disease of human beings. Dr. Goldman is to discuss the etiology and treatment of leukemia one of the most insidious and abominable of diseases. Both Dr. Pons and Dr. Goldman will bring out the close relationship between pernicious anemia and leukemia and cancer. These three processes are overgrowths of abnormal cells and all of them occasionally, spontaneously remit. The latter is the most hopeful sign that cancer can be cured. Cancer can well be a deficiency process—a deficiency of an enzyme or hormone—just as pernicious anemia is a deficiency of vitamin B_{12}.

The three fields that hold the most promise for the future advancement of medicine are, chemistry (enzymes, hormones, et cetera) physics (use of radioisotopes to understand intracellular chemistry) and psychiatry. Hematology plays a role in all three of these fields. Presumably, therefore, hematology will not vanish as it appears that some specialties such as that of infectious diseases might. In fact, there are many "Recent Advances in Hematology" as the members of the panel will now emphasize.

THE MIRACLE OF SUDDEN SIGHT*

B. BERNARD GURLAND, M.D., Bayonne, N. J.

The miracle of sudden sight after a long period of blindness was exhibited in several cases during the war. During an air-raid, an elderly and blind man or woman, thrown out of bed by the force of the bombing, would report that suddenly he could once again see. To the person affected, this seemed an Act of God. The ophthalmologist naturally looks for a material and scientific explanation. What happened was that the force and power of the bombing caused the dislocation of an opaque lens (cataract) and so restored vision. The case which I report also deals with a dislocated lens but the results of the dislocation are quite different.

A 65 year old female came to me complaining of poor vision and pain (of recent onset) in the right eye. The left eye was normal. Initial examination revealed a quivering iris (iridonesis) and the absence of Perkinje images (reflections of light from the surfaces of the lens) in the right eye. There was also a very high hyperopia in the right eye.

The pupil was dilated with ephedrine sulphate (3 per cent) and an ophthalmoscopic examination showed a dislocated lens which could be seen downward anterior to the ora serrata at the ciliary body. The intra-ocular tension was 32 millimeters of mercury (Schiotz). There was no evidence of a surgical or traumatic procedure in the eye, but the patient recalled an injury with a wire some fifteen years ago.

It was explained to the patient that the lens in her right eye was dislocated and that I would try to get the lens back in place. This must be accomplished before any other treatment could be instituted. The patient was placed on the table with her head suspended. In assuming this unusual position, it was hoped that the lens would float into place. After thirty minutes, she was placed in an upright position and was thrilled to report that she could once again see clearly. Examination showed that the lens (which was not opaque) had floated back into normal position (hyloid fossa). We explained to the patient that treatment could now be started. It was evident that the lens would not stay in place and a rising pressure gave evidence of glaucoma. It was necessary to keep the patient in the office under observation. Miotics were used and intra-ocular pressure was measured at regular intervals. The patient reported pain, which grew increasingly severe, and the vision in the right eye was blurring. The intra-ocular pressure was rising and the lens was being pushed forward due to the constriction of the iris behind it. The lens was forced into the anterior chamber and the patient was becoming myopic. Surgery must be performed to remove the lens which was causing the rise in the intra-ocular tension (glaucoma). The patient was admitted to the hospital for that purpose.

*From the Department of Ophthalmology, Bellevue Hospital and Bayonne Hospital, New York University, School of Medicine, Ophthalmology Division.

In usual cataract surgery, I employ the three corneal scleral sutures in doing an intra-capsular round pupil cataract extraction, according to the Kirby technic.[1] Since this lens was dislocated and there was a quivering iris and biomicroscopy showed vitreous in the anterior chamber, the vitreous would present itself upon section with the Graefe knife. To prevent this, the usual procedure is to employ the Stallard[2] preplaced corneal conjunctival-scleral suture. In my experience, however, in placing the scleral arm of the Stallard suture, it is difficult to be certain that scleral tissue is taken in the bite. If the scleral tissue is not taken, the sutures are corneal-conjunctival and therefore are not strong enough to prevent gaping of the wound, protrusion of the iris and herniation of part of the vitreous body under the conjunctiva.

I modified the procedure and now do it as follows. The patient is given the usual pre-operative preparation. I use chloral hydrate by rectum, barbituates and local installation. On the operating table I use demerol† intravenously. At the operation I use VanLint and O'Brien[3] lid akinesis and also an injection into Tenon's capsule, under and behind the superior rectus tendon. I also balloon up the conjunctiva around the complete circumference of the cornea. A peritomy of 180 degrees (half the corneal clock dial from 3 o'clock to 9 o'clock) is made and the conjunctiva undermined and freed from the sclera for 5 or 6 millimeters back. At this point I test to be certain that the conjunctiva will cover the wound. Two radial corneal episcleral sutures may now be placed without interference from the conjunctiva. I place them with an ophthalmic pick[1] using a 6 "O" black silk with an atraumatic needle.‡ A central suture is placed. Then the usual Graefe section is made and enlarged with the Stevens scissors. Broad base iridectomy is done and the lens is delivered by means of an intracapsular forceps, while the assistant holds the corneal flap containing the central suture down. The radial sutures are quickly tied and the central suture is placed and tied. There is minimum loss of vitreous. The anterior chamber is restored by means of an air bubble. The conjunctiva is pulled down over the incision. This patient made an uneventful recovery and vision with aphakic correction is 20/20.

The peritomy is of value in making the placement of the preplaced Stallard suture. I have used this technic successfully in 25 other cases where there were cataracts complicated by glaucoma, where there was a history of vitreous loss in the other eye or where there was reason to suspect that there would be a loss of vitreous, where the patient is a "squeezer" or where the patient is uncooperative. Further studies are in progress and a more detailed report of this procedure and technic will be published in the near future.

146 West 37 Street

† Demerol is the Winthrop Company's trade-name (registered) for ethyl methyl phenyl piperidine carboxylate hydrochloride.

‡ Manufactured by Davis and Geck.

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MEMO FOR NONVETERAN PHYSICIANS

The National Guard of New Jersey has asked that the following information be published as of interest to all physicians not now in the Medical Reserve Corps:

All doctors and interns, especially those who served under the A.S.T.P., should consider the following advantages in joining the National Guard now instead of waiting to be inducted.

1. Present selective service laws exempt National Guardsmen from immediate draft.
2. The present bill to draft doctors does not contemplate the $100 a month additional now paid to medical officers in active service. All National Guard medical officers, inducted into the active federal service, are entitled to this extra pay.
3. Acceptance of a commission in a National Guard unit *at this time* would enable a medical officer to be eligible for promotion within one year after acceptance.
4. Acceptance of a commission in a nearby National Guard unit will permit a physician to continue his private practice until the unit to which he is assigned is inducted into federal service.
5. With large numbers of physicians called in through regular channels, it seems certain that promotions in the active service will be few and far between. See advantage number 3 above.

For further information call HUmbolt 2-8220 or Trenton 5-8561 and ask to speak to the Surgeon. Or write, Adjutant General, Armory, Armory Drive, Trenton, N. J.

DIAGNOSIS OF CANCER OF THE COLON

Hyman I. Goldstein, M.D., Camden, N. J.

Carcinoma of the colon accounts for about 7 per cent of all cancer. This is the most common neoplasm of the colon, and as it may not uncommonly occur also in younger patients, it must be recognized as a major problem for the gastro-enterologist and the surgeon. Early, correct diagnosis, and prompt surgical intervention give much beter results in colonic malignancy, than we obtain in cancer of the esophagus, stomach or rectum. Early operation plus the use of sulfa drugs and antibiotics before and after operation, and the judicious administration of hydrolysates, amino acid and protein preparations, have all contributed to the higher rate of recoveries.

However too many patients still come to our attention who have gone for some time, misdiagnosed or undiagnosed, with advanced lesions so that they are inoperable, or at best, suitable only for palliative treatment.

The late Dr. Samuel Friedman of New York, in his very practical discussion, at the 1947 meeting of the National Gastro-enterological Association, emphasized the great importance of being "colon-cancer conscious". He reminded us that cancer of the colon may "sneak-in", under the disguise of simple anemia, indigestion, vague abdominal discomfort or loss of weight or with pain simulating appendicitis. Change of bowel habits and obstruction are not observed in many cases, until the disease is advanced. In lesions of the sigmoid colon, however, change of bowel habits may frequently be a presenting symptom. Obstruction too is observed somewhat earlier, when the lesion involves the splenic flexure or the sigmoid colon. Bleeding occurs more frequently as a presenting symptom in lesions of the sigmoid or recto-sigmoid in about 70 per cent of the cases. The diameter of the left colon is smaller than the right colon, and the contents of the left colon are formed and hard; for these reasons, obstruction occurs earlier. Intestinal obstruction from left colonic and rectosigmoidal growths is common. Such obstruction may often appear out of nowhere and carcinoma may not even be suspected, but is discovered only at the time of operation for the (acute) obstruction. The "left colon" usually includes the major portion of the transverse colon, descending colon and sigmoid. The younger the patient, the more rapid the growth and the greater the likelihood of metastases.

It, therefore, behooves us all never to neglect digital examination of the rectum, complete sigmoidoscopic, fluoroscopic and x-ray examinations of all patients with the slightest suspicion of disease of the colon. All general physical examinations must include a rectal digital examination, as a routine part of the procedure.

Dr. Friedman's advice as to the importance of re-examination by fluoroscope, x-ray and sigmoidoscope, until one is definitely certain there is no evidence of cancer of the colon, is timely and should be heeded. Various positions of the patient, barium enema, air-contrast roentgenologic studies and serialographic visualization of the filling rectum and sigmoid will usually determine the presence or absence of a lesion of the colon.

The contributions of Rankin, Mayo, Lahey, Jones, Coller, Graham, Gregg, Buie, Bacon, Cattell, Raiford, Ravdin, and many others have materially improved the outlook for these patients, provided, we can get them to the experienced surgeon, early enough, to give them a good chance. Let us try.

1425 Broadway

ROOM-FINDING SERVICE FOR FLORIDA PATIENTS

Announcement is made of a special room-finding service for patients going to Florida. This is a no-charge service, fashioned specifically for doctors and patients. The service locates rooms in private homes, with or without meals, with special provisions for patients who need wheel chair ramps, special diets, ground floor rooms, and the like. The address is 2054 North Second Avenue, Miami 37, Florida, and the name of the organization is "Physicians Room Service".

DECREASING MORTALITY AFTER GYNECOLOGIC OPERATIONS

Benno Tunis, M.D., Newark, N. J.

Two distinct groups of cases are found in operative gynecology: (a) cases with absolute indications (life-saving operations) made up largely of hemorrhages connected with some stage of gestation or with perforation of an abdominal viscus where only prompt surgical action can save the life; (b) operations in which surgery seems to be the *ultima ratio* but where other kinds of treatment such as hormones, radiation, et cetera may be tried (successfully or not) for some time. This group comprises all other gynecologic lesions where immediate surgery need not be applied as, for example, tumors, inflammations, protrusions, ovarian cysts et cetera.

In reviewing the literature we find that there is still an unfortunately high mortality after gynecologic operations. Thus, Miller[1] reported 401 deaths occurring after gynecologic surgery for the six year period 1937-1942, at a southern hospital. This is a mortality rate of 0.68 per cent—not too high but, nevertheless, alarming. Miller[1] estimates that 20 per cent of these deaths were preventable. A partial breakdown of the causes for these deaths was attempted and his listing follows:

Peritonitis	34
Embolism	27
Thrombo-embolisms	25
Cancer	26
Renal insufficiency	24
Respiratory	13
Anesthesia	4
Cardiac	9
Hemorrhages and shock	3

Greenhill[2] reported 213 postoperative deaths among 7812 patients, a postoperative mortality of 2.8 per cent. In deciding on an operation for some of the cases belonging to group B, we have to be very selective as to the method of operation as well as to take into most serious consideration the condition of the patient. The gynecologist will watch carefully for manifestations of bad health of the heart, kidney or veins, and he will correct such conditions as much as possible. In this way we may reduce the mortality because of heart disease, thromboembolism or respiratory diseases.

Mortality due to peritonitis, hemorrhage and shock should be decreased (a) by good technic; (b) transfusions—plasma or blood; (c) antibiotics. In this paper I will review some 100 cases illustrating both types of gynecologic surgery.

(1) A young para-3 had a bad third pregnancy due to cauterization and conization at the beginning of her pregnancy. Her membranes were ruptured four weeks before term. She was kept in bed and the start of labor by all conservative means was attempted, without success. At term, metreurysis was applied, resulting in quick dilatation and delivery of a baby in frank breech. Placenta came out normally and the condition of both the mother and child was satisfactory. Two hours later the patient suddenly began to bleed to such an extent that she was near death. A transfusion was immediately given and an abnormal hysterectomy performed at once. Thirty minutes later the mother reported that she "felt fine". This is a typical case of atomic hemorrhage probably due to a latent infection following the premature rupture of the membranes long before the delivery. This concept of infectious atonia, whereby some kind of paralysis of the uterine muscle develops, prompted my decision to remove the uterus. The mother was saved and returned to her three children.

(2) A 44 year-old woman had a normal first delivery twenty years ago. A second baby was delivered in 1950 and the afterbirth was uneventful. There was no noteworthy bleeding but the uterus became soft and then hard alternately. An oxytocic was given and for four days she bled only moderately. On the fifth day, she was very pale and hemoglobin was only 60 per cent. She was prepared for a puerperal hysterectomy on the fifth day. The operation was successful and the patient given one dosage of plasma and 2000 cubic centimeters of glucose-saline. The uterus was full of fibroids. Abundant penicillin injections (1,000,000 units daily) prevented a rise in temperature.

(3) A 32 year-old prima-para developed intestinal obstruction after a low flap Cesarean section done because of a disproportionate relationship between the head of the child and the mother's pelvis. For four days, antibiotics and Wangensteen's tube had been applied without result. Re-operation on the fifth day—removal of a large sponge left after the Cesarean and hysterectomy—was followed by a swift recovery. A transfusion of one pint of blood was given.

(4) A 36 year-old nulliparа six weeks overdue

for her delivery suddenly discharged amniotic fluid. By medical means labor pains were induced. Pain was very severe and after 20 hours of agonizing labor no progress toward delivery was evident. Twenty hours later it was found that the lower uterine segment had become distended and very painful. A Cesarean was decided upon as the course which would be most likely to save the lives of both mother and child. The baby's head was tightly embraced by the greatly distended lower segment of the uterus. The child was delivered and the uterus removed because of six fibroids at its anterior wall. Penicillin was given for five days but no blood transfusions were required. The patient recovered rapidly.

(5) A 19 year-old girl had been sick for four days with acute abdominal distention. When I saw the patient on the fourth day I diagnosed her condition as peritonitis. Immediate surgery was necessary as the entire abdominal cavity was filled with odorous *coli* pus. The appendix was damaged and the right tube and the ovary were in an abscessed condition. These organs were removed and the pus eliminated by suction. Sulfa powder was inserted into the abdominal cavity and two Penrose drains inserted. Streptomycin and penicillin together with one pint of blood were given to the patient after the operation. She recovered within ten days.

(6) An 18 year-old girl suffered from distention and ascites accompanied by high temperature. The abdomen was opened and the omentum was found with a scattering of tubercles. At the tip of the omentum majus a conglomerate tubercular tumor was found. The operation consisted only of removing the yellowish fluid by suction. The aftertreatment was 3 Grams of streptomycin daily for three months. The patient recovered completely and is now capable of performing heavy factory work.

(7) A patient was admitted with acute appendicitis. At laparotomy the appendix was found perforated and the peritoneum infected. The patient developed postoperative ileus. Streptomycin and penicillin were given in high doses. The Wangensteen tube and intravenous fluids were used. No blood or plasma was given during these four days. The patient recovered on the fifth day.

(8) A ninety-year old patient suffered from an arteriosclerotic gangrene of the right foot accompanied by high temperature and severe pain. A guillotine amputation with application of sulfa powder to the stump and 1,000,000 units of penicillin daily brought the fever down. One blood transfusion restored her to health and the patient left the hospital ten days after the operation. The heart was watched carefully and digitalis, caffein, and coramine were given for five days.

Thirty-two hysterectomies were performed: ten of them for A group indication and 22 as the *ultima ratio* in group B. Of these 32, eleven were performed vaginally and the remainder abdominally. Vaginal hysterectomies were done on patients in the more critical condition. The more robust patients had abdominal hysterectomy. Of the 21 abdominal operations, sixteen of the patients had adnexal complications in connection with fibroid tumors or hemorrhages. With six exceptions, all patients received preparatory treatment to make them more fit to undergo operation. All were over 42; some were nearing sixty, and a few were older. If possible, chronic anemia was corrected. Studies of the heart including electrocardiography were done on ten patients of the more elderly group. All recovered within eight days and only two needed transfusions. These patients received one pint of citrated blood each. All had been treated with penicillin in amounts depending on the associated pathology of the adnexa. In this connection, the following quotation[4] is interesting:

"If on opening a patient because of fibroids, one finds inflammation of the adnexa, it is advisable to close the abdomen promptly and avoid any further surgery, because of the danger of peritonitis."

This was the gospel back in 1932. Fortunately such a defeatist attitude is no longer necessary. In eight of our patients, severely inflamed adnexa were noted beside the fibroid tumors. The diseased parts were removed, but no peritonitis developed, probably because we used large doses of penicillin.

The number of hysterectomies here described is small in comparison to the many operations done in large hospitals throughout the country. However, even among 32 patients a number of casualties could easily result were the technic faulty, the cases not too carefully chosen or the aftertreatment not very thorough.

We encountered neither thrombo-embolism nor embolism. There were no cases of bladder disturbance after hysterectomies except one vesicovaginal fistula which was corrected perfectly within three months. There were no postoperative hemorrhages in either type of operation. Early ambulation was not applied. Not one patient got up before the fifth day. Ninety per cent had had spinal anesthesia.

Four cases of typical pyosalpinx were cured by removing both sacs and applying sulfa drug interabdominally. Postoperative treatment with penicillin continued. Ten were oper-

ated upon because of ovarian cysts. One twelve year-old patient had a cyst which filled up the entire abdomen. Another—a middle aged woman—had a luteoma. Each of these patients recovered and no complications were encountered.

We had to deal with six cases of cholecystitis. These were treated by simple cholecystectomy without drainage of the common duct. All recovered within ten days. Two cases, however, require further comment. In the first of these there was an enlargement of the neck of the gallbladder covering one sole stone the size of a plum. This gallbladder was on the verge of perforation. The second patient had had four earlier operations: an appendectomy, hysterectomy, and two operations for adhesions. She then complained of epigastric distress. The region of the liver (after dye) was full of spots ranging in size from that of a pea to that of a walnut. Altogether there were about 20 spots but none located inside the gallbladder. The operation revealed a very much obliterated gallbladder adherent to the omentum and other organs of the right epigastrium-like duodenum. She had a greatly distended, stone-bearing gallbladder. The stones embedded all around the gallbladder were not removed. Obviously there had been a rupture of the gallbladder with spontaneous healing and obliteration. The patient was well nine days later.

Three cases of thyrotoxicosis came to surgery. All were very severe cases and all were managed without many complications. One, a 65 year-old patient, required heroic treatment including an oxygen tent and penicillin because of a postoperative crisis. All were discharged eight days after the operation. Naturally all had been prepared for thyroidectomy with bedrest and sedatives for from two to four weeks; also, with iodides and thiouracil. Antibiotics were given for five days following the operation.

Appendectomy was done in 16 patients ranging in age from six to seventy years. Eight of the appendices were gangrenous. Two of the patients were 70 years old; two others from 60 to 70; and the last two cases from 6 to 12 years of age. All but the two youngest received spinal anesthesia. The aftertreatment was supported by antibiotics.

Two cesarean sections were done: one because of placenta previa and the other because of disproportion. Postoperative treatment was supported by antibiotics and there were no complications. We also had one adenocarcinoma and three scirrhus carcinomata of the breast. Radical mastectomy was performed and all received radiation treatment two weeks later.

To complete our analysis of surgical cases reviewed the following operations require listing:

(1) Two hernias with local anesthesia. There were three veins in ligation and in one case a suspension of the uterus.
(2) Four colpoperineoplasties.
(3) Two patients with ectopic pregnancy who recovered after operation.

SUMMARY

1. Emphasis is placed on modern surgical principles, particularly: (a) proper indications, (b) scrupulously careful preparation, (c) antibiotic therapy, and (d) transfusions when necessary.

2. Accounting is made of more than one hundred consecutive operations, mostly gynecologic, accomplished in accordance with these principles, in which there were no fatalities. It is noted that eight of these patients were essentially moribund, needed the operation desperately as a live-saving measure, and all of them recovered.

Acknowledgement. Gratitude is expressed to the Doctors' Hospital (Newark, N. J.) and especially to its director, Dr. I. E. Fink, and to Dr. S. Goldstein, Senior Surgeon at the Hospital.

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22 Ingraham Place

BLEEDING MECKEL'S DIVERTICULUM

REPORT OF CASE IN AN 18-MONTH OLD INFANT *

Thomas V. Morton, Jr., M.D., George L. Kline, M.D., and
Nathan Zuckerberg, M.D., Newark, N. J.

Eighty per cent of the cases of Meckel's diverticulum in children under two years of age, are first discovered because of massive rectal hemorrhage. Ladd and Gross[1] in a survey of 73 cases, found 26 in which the child had hemorrhage due to peptic ulcers in the neck of the diverticulum sac. Jay *et al.*[2] noted that bleeding was the major symptom in 75 per cent of the children with Meckel's diverticulum who were under ten years of age. Wilkinson[3] is credited with reporting the youngest patient with massive hemorrhage from a peptic ulcer in a Meckel's diverticulum. His patient was a female infant only eleven months old. Younger children have had pathologic processes involving a diverticulum, but Wilkinson's is probably the youngest with hemorrhage reported to date.

We are presenting this case to emphasize the importance of early diagnosis and swift surgical intervention in infants who have painless rectal hemorrhage of undetermined origin.

An eighteen month old white male infant was admitted* with a history of rectal bleeding of 48 hours duration. On the day prior to admission, the child had a normal bowel movement followed by a diaper full of bright red blood. On the day of admission, episodes of rectal bleeding were noted at 10:30 a. m. and 3.30 p. m. At no time was there any notice of abdominal pain. The only positive findings noted by the mother were persistent temperature elevations to 100 degrees for three days prior to admission.

Birth had been normal with an initial weight of six pounds and a steady weight gain. There have been no childhood diseases except frequent colds during the past year. Family history was irrelevant.

Physical examination revealed fair skin turgor; somewhat pale but exhibiting good muscle tone. The head was symmetrical. Slight nasal discharge was present. The child had eighteen teeth. His pharynx was clear. The lungs, eyes and ears were normal. The heart exhibited no enlargement, but there was a sinus tachycardia with regular sinus rhythm. The abdomen was flat and soft. There were no masses, no splinting, no rigidity and no tenderness. Reflexes were equal, and active bilaterally. Rectal examination revealed dark and bright red blood on the examining finger. Blood count showed 43 per cent hemoglobin and 2,000,000 red cells.

X-ray examination by barium enema disclosed no definite pathologic process.

Operation: After a transfusion of 150 cubic centimeters of whole blood and anesthesia induction using ether by open drop, a lower right paramedian incision was made. A diverticulum of the ileum about one centimeter in diameter and two centimeters in length was seen 25 centimeters from the ileocecal valve. The diverticulum was excised in the long axis of the ileum. The bowel was closed in the transverse axis with a continuous Connell suture. The first layer was reinforced with a layer of interrupted Lembert sutures. The abdomen was closed in layers. It was noted that the ileum distal to the diverticulum was darkened with old blood.

The patient enjoyed an uneventful recovery. His highest temperature was 100.8 on the first two postoperative days. He received 2,450,000 units of penicillin and 9.75 Grams of streptomycin in the immediate postoperative period.

Pathologic report: The specimen was a small bit of tissue in formalin, sac-like in configuration. Microscopic examination revealed a section of small bowel in which all layers were intact. There was definite displacement of the mucosa with gastric mucous membrane containing tall glands with numerous acid secreting cells present. No areas of true ulceration were seen, but in two regions there was interstitial hemorrhage and inflammatory reaction.

Pathologic diagnosis: Meckel's diverticulum.

685 High Street

* Surgical service of the Hospital of St. Barnabas and for Women and Children, Newark, N. J.

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STATE ACTIVITIES

GRADUATE MEDICAL COURSES AT SETON HALL

The enormous success of the graduate courses sponsored by Seton Hall University under the sponsorship of the Essex County Medical Society has resulted in demand for further courses this year. A table of the 1950-51 courses is appended. This is approved under Public Law 346 for physician-veterans. Non-veterans apply for courses by mailing check to Director of Admissions, Seton Hall University, South Orange, New Jersey. Physicians availing themselves of Public Law 346 should mail the certificate of eligibility to Dr. Gerald Cetrulo, Director of Medical Education, 40 Clinton Street, Newark 2, New Jersey. For further information, communicate with Dr. Cetrulo.

Subject	*Day and Hour*	*Place*	*Starts*	*Fee*
Abdominal Surgery	Mondays 4 p. m.	C	October 9	$200
Abdominal Surgery	Fridays 4 p. m.	C	October 13	200
Anesthesiology, regional	Wednesdays 4 p. m.	C	October 4	100
Amputations	Wednesdays 4 p. m.	K	October 4	100
Biochemistry	Wednesdays 4 p. m.	N	October 11	100
Cardiology for G.P.s	Wednesdays 4 p. m.	M	September 27	5
Cardiology, advanced	Thursdays 9 p. m.	S	October 12	100
Diagnostic roentgenology	Tuesdays 4 p. m.	U	October 10	100
Endocrinology	Mondays 9 p. m.	S	January 8	80
Electrocardiography	Fridays 4 p. m.	N	October 13	100
Electrocardiography, unipolar	Mondays 4 p. m.	S	October 9	75
Gynecologic pathology	Saturdays 11 a. m.	S	October 14	100
Gynecology	Saturdays 3 p. m.	S	February 24	100
Internal medicine	Fridays 4 p. m.	S	October 13	125
Ocular therapy	Tuesdays 4 p. m.	E	October 24	50
Peripheral Vascular dis.	Tuesdays 4 p. m.	N	October 10	75
Pathology, gynecologic	Saturdays 11 a. m.	S	October 14	100
Pathology, surgical	Saturdays 9 a. m.	S	October 14	200
Regional anesthesiology	Wednesdays 4 p. m.	C	October 4	100
Roentgenology, diagnostic	Tuesdays 4 p. m.	U	October 10	100
Surg. Anatomy of chest	Mondays 4 p. m.	C	February 19	150
Surg. Auton. nerv. system	Fridays 4 p. m.	C	February 16	100
Surgical pathology	Saturdays 9 a. m.	S	October 14	200
Unipolar electrocardiography	Mondays 4 p. m.	S	October 9	75
Vascular diseases	Tuesdays 4 p. m.	N	October 10	75

KEY TO LOCATIONS:

C—City Hospital, 117 Fairmount Avenue, Newark
E—Eye and Ear Infirmary, 77 Central Avenue, Newark
K—Kessler Institute, Pleasant Valley Way, West Orange
M—St. Michael's Hospital, 306 High Street, Newark
N—Nurses' Home, 116 Fairmount Avenue, Newark
S—Seton Hall campus, South Orange
U—Urban Division (Seton Hall), 40 Clinton Street, Newark

JAMES F. NORTON, 1892-1950

Continued from page 454

ficial resolution of the Board of Trustees and other well-earned tributes. Newspapers both in and out of New Jersey have already told their publics of the career of Jim Norton. For us here in the executive and editorial offices, his death comes as a personal loss, for among his many interests, The Medical Society of New Jersey was surely one of the closest to his heart.

EVOLUTION OF THE WELFARE COMMITTEE

As President Crowe aptly puts it, our Welfare Committee is unique—no other medical society has any unit quite like it. It is a large committee consisting of sixty members, with every county society represented. It supervises the work of four subcommittees: legislation, medical practice, public health and public relations. The subcommittees in turn have administrative jurisdiction over a number of technical advisory committees, running the alphabetical gamut from adult diseases to workmen's compensation. When new technical problems arise, new advisory committees can be swiftly established to cope with them. This gives the Welfare Committee structure an added virtue: flexibility. With the assets already listed by Dr. Crowe (integration, discussion and communication) it adds up to an amazingly effective device.

The Welfare Committee began modestly enough some thirty-one years ago. It was born in the fertile brain of Dr. Thomas W. Harvey, the retiring President who in his 1919 message suggested a new committee—"I do not know what its title should be" said Dr. Harvey, "but its purposes should be those of an active agent in forwarding the welfare of the profession". Dr. Harvey then listed three immediate functions: (1) The recruitment of new members for the society, (2) Interest in the various "social insurance programs" then being talked about in New Jersey, and (3) Assuring that there would be medical representation in "conferring with Employers' Associations, Labor Unions and insurance carriers with respect to the status of medical men". The last phrase, which sounds somewhat mysterious today, referred to the early workmen's compensation act which was then at a stage of development where such problems as medical fee schedules and medical testimony were being discussed.

The Trustees acted on Dr. Harvey's recommendation by creating a five man "Committee on the Welfare of the Profession" in May 1919. Dr. Harvey was made chairman and Dr. Eagleton secretary of the infant committee. It will be noted that at the time it was a very small body (only five members) and its principal function was in the area of legislation. In the October 1919 issue of this Journal, our distinguished predecessor, Dr. D. C. English, suggested that the "suppression of pretenders and quacks is one of the most important subjects that can be considered by the Committee on the Welfare of the Profession". This is interesting because it added a public educational function to an essentially legislative program: or, more exactly, it recognized that the promotion of good legislation was more appropriately a matter of education than a matter of lobbying. Dr. English also re-emphasized a principle that is one of the glories of our profession: "the welfare of our profession is best maintained by zealous efforts for the welfare of the public".

In 1920 the committee retained its first paid employee. Mr. Joseph H. Gunn was selected as a legislative representative. He had the added duty of stimulating the organization of a "Committee of Five" in each county society. This "Committee of Five" was planned as a miniature Welfare Committee at the county level, and still sounds like a good idea. What happened to the idea we don't know.

In the Committee's first report to the House of Delegates the body was listed in the July 1920 Journal as the "Welfare Committee", this being, as far as we can determine, the first official use of the shorter and simpler title. Up to this time, the committee had no constitutional existence, having been established by simple resolution of the Board of Trustees. Passed that year, was a new bylaw which formally recognized the Welfare Committee under that title. The number of members was fixed as "at least five" and its duties were to include all the functions of the old Legislative Committee, and "all questions of professional welfare" not otherwise provided for. It was further instructed "to establish close alliance with the county medical societies," thus for the first time officially recognizing the "two-way-communication" feature of the Committee which is now so important.

Under Dr. Eagleton's vigorous chairmanship (a fact which will surprise no one) the Committee's activities expanded enormously. By 1923, Dr. Eagleton was reporting on venereal disease control, nursing, medical testimony and "state medicine" as well as on legislation. Though the pattern of subcommittees and advisory committees had not yet jelled, we see in this expanding range of activities the *anlage* for such a structure. The excursions of the committee into these other fields highlighted the need for a smooth public relations program and in 1925 a subcommittee was created for that purpose. Advisory committees had not yet been established, so that in 1925 we find subcommittees on juvenile delinquency,

medical testimony, workmen's compensation, medical practice, and public relations. The latter two still remain as subcommittees whereas the other three have since had their functions assigned to advisory committees.

In 1924 the Society had engaged Dr. Henry O. Reik as editor of The Journal and executive secretary of the Welfare Committee. By 1925 Dr. Reik was reporting on a long list of matters of general interest. Because he worked in the executive offices of the Society (then in Atlantic City), Dr. Reik was able to pull together the many threads to form a single integrated pattern and he thus established the integrative function which has since been a characteristic of the Welfare Committee.

Advisory committees began to function in 1926 and multiplied with the increasing complexity of medical practice. By this time it was apparent that the Welfare Committee could no longer serve as a direct operational body. It had assumed supervisory, integrative, communicative and planning functions, but actual operation had to be delegated to smaller and more specialized bodies. Accordingly in April 1937 the By-Laws were amended establishing the present large Welfare Committee with all-county representation, and specific echelons of subcommittees and advisory committees.

From the beginning, the Welfare Committee has had chairmen of unusual distinction. The chairman's function is much like that of a Speaker of a House of Delegates, and the post is one that requires poise, fast-thinking, diplomacy and leadership. That these qualities have been found is shown by this roll-call of those who have been chairmen of the Welfare Committee since its founding: Dr. Thomas W. Harvey (1919); Dr. Wells P. Eagleton (1920 to 1924); Dr. Andrew McBride (1924 to 1929); Dr. A. Haines Lippincott (1929 to 1932); Dr. Charles H. Schlichter (1932); Dr. Frederic J. Quigley (1933); Dr. Thomas B. Lee (1934); Dr. Hilton S. Read (1935 to 1942); Dr. Herschel S. Murphy (1942 to 1944); Dr. J. Howard Hornberger (1944); Dr. Sigurd W. Johnsen (1945); Dr. Hilton S. Read (1946); Dr. Vincent P. Butler (1947 to 1950); Dr. Samuel Blaugrund (1950).

Henry A. Davidson, M.D.

SUPPLEMENTARY LIST No. 6 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Bossone, Joseph E., 362 Bath av., Long Branch (13)
Brodkin, Louis A., 32 Johnson av., Newark (7)
Carroll, Daniel B., 15 Atno av., Morristown (14)
Cordasco, Peter, 517 Roseville av., Newark (7)
De Vivo, John A., 188 S. Sixth st., Newark (7)
Fischman, Mervin, 264 Clinton pl., Newark (7)
Goldstein, Joseph D., 681 Bergen av., Jersey City (9)
Kralik, Joseph J., 555 Market st., Newark (7)
Lease, Henry J., 111 74th st., Woodcliff (9)
Levinstone, Bertram, 23 Chancellor av., Newark (7)
Levitov, Leo, 246 Union st., Jersey City (9)
Lupo, Domenic, 763 Broadway, Newark (7)
Mango, Concetta G., 1 78th st., North Bergen (9)
Milligan, Robert S., 42 Elm st., Summit (20)
Minnella, Thomas J., 268 Springfield av., Summit (20)
Morton, J. Wilk, 374 Speedwell av., Morris Plains (14)
Norwich, Louis E., 355 Avenue C, Bayonne (9)
Shuttleworth, John E., 7015 Deerfield rd., Colonial Village, Pikesville, Md. (4)
Sirkin, Charles, 887 Summit av., Jersey City (9)
Thomson, Carroll S., 17 Elm st., Morristown (14)
Utkewicz, Edmond A., 2633 Boulevard, Jer. City (9)

ACTH NOW RELEASED

The Food and Drug Administration has released ACTH for general use. It is available for both hospital patients and outpatients. Further information as to the price and availability of ACTH may be obtained from the original developer, Armour Laboratories, Chicago.

It has been reported that there exists a "gray market" in ACTH and that some physicians and patients are buying the drug at seven times the current retail price charged by the larger reputable laboratories. Since the drug is now available through normal channels physicians are urged to inquire first from the regular manufacturers.

A.M.A. SESSION FOR GENERAL PRACTITIONERS

The clinical session of the A.M.A. to be held in Cleveland December 5 to 8 has been programmed primarily for the general practitioner. To permit each doctor to take a lively part in the discussion, attendance is limited to 100 physicians at each session. So if you can come to the Ohio metropolis in December, write the Secretary of the A.M.A. (535 North Dearborn Street, Chicago 10) at once to reserve your registration. Here is a fast preview of the highlights of the December session:

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention. Top-notch leaders of each field under discussion will be available to help with the problems presented.

In *obstetrics,* difficult cases of interest will be featured. Especially stressed will be breech deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual *pediatric* patients have been programmed. Care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

The section on the management of *heart cases* will discuss hypertension, recent advances in drug therapy (including ACTH) as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias.

Of special interest will be discussions on parkinsonism, the use of the electro-encephalograph, electric shock therapy and psychotherapy in a section on *neuropsychiatry* in general practice.

There will be discussions on fluid replacement in shock, renal repairment, dehydration and other topics in *geriatrics.*

Of unusual interest will be new studies and clinical histories involving *traumatic surgery.* This will include material on reconstructive surgery, emergency analgesia and emergency surgical measures.

Taken up in detail will be the management of postoperative or inoperable *cancer patients.* The use of analgesics and the effects of hormone and radiologic treatment will be discussed.

An excellent program has been arranged covering *diabetes.* This will include diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

Papers covering practical problems in *dermatology and syphilology* will be presented. Deep fungus infections and industrial, allergic and contact dermatoses will be demonstrated and discussed. Emphasis will be put on the newest developments in syphilology.

New developments and refinements of older technics will feature the discussions on *anesthesiology.* Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

Outstanding speakers will discuss ulcers, jaundice, infectious hepatitis, cirrhosis and other *gastro-intestinal diseases.* Newest advances in medicine and the use of many newer drugs and their application to the general practice of medicine will be presented in another section. Of special interest will be the discussions on the use of antibiotics, hormones and antispasmodics.

Color television will have a place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It is sponsored by Smith, Kline & French Laboratories.

DIABETES DETECTION DRIVE
November 12 to 18, 1950

This is part of a national drive sponsored by the American Diabetes Association. The New Jersey Diabetes Association is behind it in this state. Object of the drive is to discover the unknown diabetics in New Jersey. Statistics show that there are as many unknown diabetics as known diabetics in any community. This was proved at Oxford, Mass., where every person in the town was screened by the U. S. Public Health Service. There were a known number of diabetics in the town. Exactly the same number of unknown diabetics was discovered by the investigators.

To discover the unknown diabetic, detection centers will be established in all hospitals in the state, during the week of November 12. Here urine specimens may be brought for free examination. The specimens must be accompanied by a slip with the name, age and address of the patient, and the name and address of his physician. All positive tests for sugar will be referred back to the physician for final diagnosis and treatment.

The New Jersey Diabetes Association will be glad to assist in arranging for speakers at medical meetings and meetings for lay groups.

HOME FOR CARDIAC CHILDREN

The U.O.T.S. Home for Cardiac Children (formerly the Theresa Grotta School located in Caldwell, New Jersey) opened its new home at 112 Washington Street, East Orange, on October 2, 1950. Children with rheumatic heart disease or congenital lesions will be accepted.

Application for admittance should be made to Miss Ida Miller, Director, at the above address.

GENERAL PRACTITIONER WANTED

Unusual opportunity for ambitious GP to engage in private practice in south Jersey town only 20 miles from Philadelphia drawing from market area of 8000 people. If interested write to Executive Offices, 315 W. State Street, Trenton 8.

OBITUARIES

DR. HALSEY S. BRAMBLE

Dr. Halsey S. Bramble, well-known Elmer physician, died on August 7, 1950, at Shore Memorial Hospital, Somers Point.

Dr. Halsey was born in 1880 in New York state. He attended Temple University and was graduated from Jefferson Medical College in 1905. He practiced in Philadelphia following graduation and moved to Elmer in 1918. He had been school physician in Elmer for many years.

DR. HENRY COGAN

Dr. Henry Cogan, former senior obstetrician at Paterson General Hospital, died at his home in Daytona Beach, Florida, on July 16, 1950.

Born in Russia in 1867, Dr. Cogan was a university law school graduate. He migrated to the United States and, after studying pharmacy, conducted a drug store in New York City for a number of years. At the age of 35, he decided to study medicine and was graduated from the New York University College of Medicine in 1907. After interning in Bellevue Hospital, New York City, he came to Paterson to establish his practice. Dr. Cogan was active in the Passaic County Medical Society and served as treasurer. He retired in 1939 and in 1949 was elected an emeritus member of his county and state societies.

DR. HAROLD D. CORBUSIER

One of the most extraordinary and colorful careers in modern medicine came to a close on August 31, 1950, with the death on that date of Dr. Harold Corbusier, a member of the Union County Medical Society. Born in 1873, Dr. Corbusier received his M.D. degree from the University of Michigan in 1899. Military medicine was one of his major interests and he organized and commanded the first medical unit of the New Jersey National Guard. During World War I, he organized the orthopedic service of the Surgeon General's office. He was a pioneer in manpower salvage, a concept launched with his system of "Recruitment Rehabilitation" in 1917.

Dr. Corbusier was on the orthopedic faculty of the New York Post-Graduate Medical School, and organized the orthopedic department at the Muhlenberg Hospital in Plainfield. At one time or another he was president of the Academy of Physical Medicine, the Association of Military Surgeons, the Plainfield Board of Health, the Plainfield Recreation Council, and the Union County Medical Society.

DR. EDWY L. MINARD

Dr. Edwy L. Minard, an East Orange physician for 40 years until his semi-retirement four years ago, died suddenly on July 22, 1950, at his home in Boonton Manor. He was head of the children's department of Women's and Children's Hospital, Newark, for 30 years until the institution merged with St. Barnabas's Hospital. Afterward he was a member of St. Barnabas's courtesy staff.

Dr. Minard was born in Montville in 1882. He studied at Cornell College and received his medical degree at Long Island College of Medicine in 1907. He interned at Mountainside Hospital and shortly after began his practice in East Orange.

From 1946 until 1948 he was medical director of Babies' Hospital - Coit Memorial, Newark. He also had been affiliated with Presbyterian Hospital and the Crippled Children's Hospital, Newark. He was an emeritus member of the Essex County Medical Society and The Medical Society of New Jersey.

DR. JOHN V. SMITH

Dr. John V. Smith, a member of Perth Amboy's original board of commissioners, died at his office of a heart attack on July 14, 1950.

Dr. Smith was born in Perth Amboy in 1888. He received his medical degree in 1912 from the Long Island College of Medicine. He interned at St. Peter's Hospital, Brooklyn, and at St. Francis Hospital, Jersey City. He was city physician from 1923 to 1926, and from 1926 to 1934 served two terms as commissioner of public works.

Dr. Smith was a member of the New Jersey State Board of Institutions and Agencies and a Fellow of the American College of Physicians.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

The structural organization of the Medical and Health Preparedness Committee of the New Jersey State Civil Defense set-up was completed at the end of August. Dr. Daniel Bergsma, State Commissioner of Health, was named chairman of the Medical and Health Preparedness Committee earlier in the summer by Leonard Dreyfuss, of Essex Fells, State Director of Civil Defense.

The Committee has been organized functionally into four sections: medical services; health services; sanitation services; and nursing, hospital, rescue, and community services. Each section has four subcommittees. The chairman of each subcommittee is a member of his respective section.

In addition to these sixteen subcommittees, two other subcommittees report directly to the Committee's deputy chairman. These are the subcommittees on maternal and child services, and medical and health information. Planning in these two areas must be part of the thinking of all the other subcommittees and these two could not be logically confined to any of the four specialized sections.

The Section on Medical Services will develop an integrated medical service plan. It will involve therapy at the site of an emergency, where there may be a great lack of equipment and personnel, and follow-up therapy at a distance from the site of catastrophe. Subcommittees of this section will plan for services dealing with radiant burn and radiation sickness, traumatic injuries, and physicians' resources.

The Nursing, Hospital, Rescue, and Community Services Section will map out an integrated health services plan and make plans for emergency hospitalization, use of such facilities as may be available after an attack or other catastrophe, other emergency space for casualty evacuation, integration of general public health nursing services, first aid to casualties, and emergency ambulance service.

The Section on Health Services will make plans for mass immunization, mass blood typing and Rh factor typing, development of a state-wide blood bank, and identification and registration involving both the living and the dead, and preventive mental hygiene.

The Section on Sanitation Services will make plans dealing with emergency water supplies and sewage disposal measures, food and drug control, and decontamination. It will plan for inventorying and indexing of emergency supplies so that appropriate supplies can be sent to areas of need in the shortest possible time. It also has responsibility for planning for the detection and control of chemical bacteriological, and radiological hazards.

Committee members have been asked to base their planning on a "temporary emergency standard". This assumes that an atomic explosion has just occurred over a sizable New Jersey city. It outlines in detail the prospect that would face the medical and health workers of a civil defense organization in such a catastrophe. The standard is based on the experience of Hiroshima and Nagasaki. It is felt that if committee members prepare for the worst, their plans should be more than adequate for some emergency less than the worst. The planning of the committee will be helpful in handling all catastrophes, large or small, but the intent is to be sure that uniformly throughout the committee, consideration is given to the worst as well as to lesser possible catastrophes.

BOOK REVIEWS

The Cytologic Diagnosis of Cancer. By the staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital, a Gynecologic Service affiliated with the Massachusetts General Hospital, Boston; The Department of Gynecology, Harvard Medical School. Pp. 229. Philadelphia and London, W. B. Saunders Co., 1950. ($6.50)

Not so long ago it was said that a single malignant cell could not be morphologically distinguished from a normal one. George N. Papanicolaou and his associates have shown the error of this concept. They have laid down criteria now accepted by every pathologist interested in the diagnosis of desquamated malignant cells.

Cytological Diagnosis of Cancer follows the footsteps of Papanicolaou to whom the book is dedicated. This sound book should be read, reread and then placed conspicuously on the shelf of a readily available reference library.

The method of presentation is thoroughly illustrated in the chapter on the vaginal smear for the diagnosis of cervical cancer. First, a formal biopsy section illustrates the normal cytologic pattern of the cervical epithelium. This is intended to convey what cells may be encountered in desquamation. Desquamated cells are then illustrated under low power. The same field is scrutinized under high power. Finally (in order to drive home the characteristics of the cells) a faithful replica, drawn by hand is given, emphasizing points to be observed. A key diagram facilitates further the identification of cells. The difficulties encountered in the recognition of what is benign or malignant are fully described, and specific criteria are given for the malignant cell.

In carcinoma of the cervix a photomicrograph of a formal biopsy of cervical carcinoma illustrates what can be expected in desquamation of these cells. A low power "spotting field" picks up suspicious or malignant cells. The malignant cells seen remind one of Ewing's characterization of them as "black and wicked". The high power and the hand drawn illustration show why the malignant cells are "black and wicked" by convincing elaboration on the structure of the chromatin content of the nuclei.

The chapters that follow on the respiratory, stomach, renal epithelia, benign and malignant, follow the same pattern of presentation. There is also a chapter on radiation changes in malignant cells. Hints are offered to stimulate the observer to further search for malignant cells not readily found, as when there is blood in the smears of the nonmenstruating women or tetrads in gastric contents.

The book is profusely illustrated with excellent photomicrographs and hand drawn fields. A number of the latter are in colors. The test is lucid and easily read. A comprehensive chapter on technic and an extensive bibliography complete this fascinating and informative book.

A. R. Casilli, M.D.

Medicine of the Year, 1950. Edited by 23 authorities. J. B. Lippincott, Philadelphia, 1950. (204 pages). ($5.00)

It is difficult to know for whom this book is intended. A specialist is not likely to want a volume in which 90 per cent of the material covers subjects outside his field of interest. Nor will the general practitioner find much usefulness in the distinction between I^{131} and I^{127} or in the many other highly specialized details. The book is of awkward page size—the cover measures about 9 x 11 inches—so that it does not lend itself to comfortable armchair reading. While each of the section editors is a specialist of unquestioned eminence, the selection of material for each subject is limited to surprisingly few articles. Thus, the book is offered as a record of significant advances in 1949. Yet in the vast field of allergy, only six articles are abstracted. One wonders if this can possibly constitute a fair cross section of advances in allergy in a full year. The entire march of orthopedics in 1949 is represented by citations of only eleven papers, and otolaryngology is disposed of in an even dozen references. It is hard to determine by what method the editors selected so few papers in each specialty, and the coverage of each subject is necessarily uneven. The book has the distinction of being the only volume I have ever seen which reviews fractures without presenting a single x-ray and dermatology without any photographs. As a matter of fact, there is not a single illustration in the entire volume.

On the asset side of the ledger, it must be recorded that the abstracted material is treated with critical acumen, and not just parrotted; and that a thumb-index arrangement makes it easy to find the larger subdivisions of the volume. There is also a well-done index at the end of the book.

Ulysses Frank, M.D.

The Salt-Free Cook Book. Emil Conason, M.D. Pp. 137. Lear Publishers, New York, 1950. ($3.)

During the past years there has been a flurry of attention to the use of low sodium diets in high blood pressure, congestive failure, nephritis, edema of liver cirrhosis, Meniere's disease, eclampsia, premenstrual tension, epilepsy and other conditions. Although scattered information on the application and benefits of the "salt-free" diet has appeared in many places, this has never before been collected in one complete and handy reference. This is what the authors have attempted and they have provided in this small book an excellent working reference for the doctor, the institution and the patient. Dr. Conason opens with a brief introduction to the development of the salt-free diet and then gives a practical series of menus integrating sodium content, caloric value, and carbohydrate content where applicable in the diabetic diet. Pains have been taken to work out a variety of meals designed to overcome the frequent resistance to the insipid fare generally imposed upon those requiring freedom from salt. The menus are supplemented in handy

recipes and salt content tables making possible even greater variety through the substitution of other foods with low sodium content.

A section with considerable use is entitled, "Low sodium diet for the person who eats out". While certainly not the last word on this difficult problem, it shows again that the dieter may eat out and still remain on the required diet. The book closes with a very complete table listing 600 basic foods and their salt content in the amounts described. From personal experience this table alone makes the book worth while to anybody who is prescribing these diets. The dieter will in most cases appreciate ready access to this volume so as to answer his own questions and satisfy his individual tastes.

Franklin Simon, M.D.

A Manual of Cardiology. By Thomas J. Dry, M.B., M.S. 2d ed. Pp. 355 with 97 figures. Philadelphia, W. B. Saunders Company, 1950. ($5.00)

This second edition is a little text, written simply, concisely, clearly and logically. It is surprising how much is covered in such little space. This is accomplished by "weeding out" much of the superfluous which usually creeps into standard textbooks. The whole book is done well but if one were to select a part which excels, that chapter would be the one on congenital heart disease.

The book is recommended for the medical student, intern and the busy general practitioner who desire a ready reference. It will be a stimulus for more extensive reading on the subject. If there is need for a manual on cardiology this meets the need.

Marvin C. Becker, M.D.

Sex Without Fear. By S. A. Lewin, M.D., and John Gilmour, Ph.D. Lear Publishers, 105 E. 15 St., New York City. 1950. ($3.00). Pp. 121 with 45 illustrations and a hundred marginal line drawings.

In spite of its theatrical title, this is a sober down-to-earth little book intended for distribution to patients by their physicians. It is not available to the general public, and is sold only to professional persons, with discount for quantity purchases. This is an interesting experiment in ethical distribution and one wonders how it will work out. The book covers the anatomy and physiology of the reproductive system, has a chapter on "the art of intercourse" which, actually, deals with the mechanics of coitus, and sections on frigidity, pregnancy, sex education, potency, the menopause, venereal disease and birth control. The language is lucid, and while the authors never talk down to the reader, the text is easily understood by any intelligent layman. Except for a tendency to be sweepingly dogmatic on numerous controversial points, the doctrine is sound.

Victor Huberman, M.D.

Harvey Cushing: Surgeon, Author, Artist. By Elizabeth H. Thomson, Henry Schuman, New York, 1950. Pp. 346. ($4.00).

The whole field of brain surgery is built on the work of Harvey Cushing. Here is a biography which somehow weaves into words the great and restless spirit of this pioneer American physician. Salted with personal letters to and from Dr. Cushing, with numerous anecdotes and with conclusions drawn from previously untapped sources, the book gives an engaging and interesting picture from the day when Erastus Cushing (Harvey's grandfather) drove from Massachusetts to the Western Reserve (Ohio) to start his practice and rear his family. Miss Thomson then traces the personal, educational and professional career of Harvey Cushing, painting it against a vivid background of late-Victorian and early 20th century America. Harvey Cushing was, of course, one of those men who makes us feel proud of our profession. This charming story of his life and times will renew that pride in any physician who reads it.

Samuel Sherman, M.D.

Speech Problems of Children. Edited by Wendell Johnson, Ph.D. Prepared for National Society for Crippled Children and Adults by the American Speech and Hearing Association. Grune and Stratton, New York, 1950. Pp. 261. ($3.75)

As a help to parents, physicians, teachers and others concerned with school children affected by speech problems, several leading speech correction workers and speech pathologists have collaborated in writing "Speech Problems of Children", a guide to care and correction.

In language understandable to the layman, the book contains chapters on the major speech disorders. At least 3,500,000 school children need speech correction, but only about ten per cent of this large group receive the attention and training they need.

To help bring this training to the children who need it, the association, which is the professional organization of speech and hearing correctionists, prepared the book for the National Society for Crippled Children and Adults. Chapters cover a broad survey of the problem, speech in the home and speech in the school, children who "don't talk plain," children who are slow in learning to speak, children with cleft lip and cleft palate, children with cerebral palsy, children with voice disorders, children with hesitant speech, children of foreign tongues and children with impaired hearing. The book contributes to a better understanding of speech problems and procedures for coping with them.

William Schram, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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HOSPITAL authorities have long evinced real concern over the possible hazard of tuberculosis in the hospital environment and today there is evidence of a growing demand for the routine use of more thorough measures of prevention, many of which would formerly have been considered experimental or extraprecautionary.

TUBERCULOSIS AMONG HOSPITAL PERSONNEL

More than a decade ago published reports demonstrated for the first time that the tuberculinization of the young adult population in the United States was significantly below 100 per cent. This downward trend in the proportion of reactors which is still being reported has been noted in studies of entering medical and nursing students.

On the other hand, according to evidence which has accumulated during the past decade, the acquisition of primary tuberculous infection among hospital personnel is extremely rapid, compared with the rate of infection of other young adults.

It is known that active tuberculosis exists unrecognized in the general population. The experience of Selective Service and mass X-ray surveys of civilian populations has demonstrated that the prevalence of active tuberculosis in our adult population is roughly 500,000 cases of which an estimated one-half are unknown to the health authorities.

If this is true, the nurse is regularly exposed to unknown tuberculosis in caring for patients on the general medical and surgical wards at an age when her sex suffers high morbidity and mortality from this disease. Most authorities agree that the undiagnosed tuberculous patient in the general hospital is one of the chief sources of infection today. Studies of medical students show that hazards of infection unrelated to clinical work also exist, as in autopsy or laboratory work.

Admittedly, the relative importance of factors responsible for development of tuberculous disease is a complex subject. In most cases infection by the tubercle bacillus leads to a reaction which is innocuous. It is believed that frequent and heavy exposure, however, will overcome immunity.

In the final analysis, tuberculosis as an occupational hazard among hospital personnel must be measured in terms of active disease suffered by these persons and not by the amount of tuberculous infection incurred by them. The problem is to ascertain whether or not tuberculosis develops more frequently among persons working in a hospital environment than elsewhere. Although there is no unanimity on this point, many authorities do believe that nurses suffer a greater hazard of developing tuberculosis than do other young women.

In evaluating the tuberculous risk in the hospital, however, it must be realized that more frequent case finding in hospitals will result in higher morbidity rates in these institutions than in the general population. Also, most hospital studies show very low mortality rates among their personnel, which may be attributed to early diagnosis and proper treatment.

Although most authorities agree that tuberculosis is an occupational hazard for medical and nursing personnel, agreement ends and controversy begins when the effect of the tuberculin reaction on the development of active tuberculosis is discussed. Studies show little agreement but many indicate an excessive morbidity in a relatively brief period after conversion from a negative to a positive reaction.

In any analysis of tuberculosis morbidity in relation to the original tuberculin reaction, however, it must be noted that, first, nonreactors represent

a group more susceptible to tuberculosis because they have not been subjected to infection, whereas the reactors have already met the test of infection; second, sensitivity to tuberculin may be lost more frequently than has been realized. If this is true, we may be considering among original nonreactors some persons who have lost sensitivity; therefore resulting proportions may not be valid. Third, in evaluating morbidity trends, considerable numbers of persons must be studied because of the low morbidity from tuberculosis in our population. Fourth, the type of tuberculosis seen in the United States may differ from that in other countries. Certain authorities have noted that young women in this country appear to be highly resistant because of genetic, environmental, or nutritional factors.

In many general hospitals, efforts have been made in recent years to minimize the hazards of infection for the student nurse by shortening the training on the tuberculosis service or by giving it to reactors only. Aseptic techniques have been increasingly stressed when caring for tuberculous patients. Nevertheless, incidence of infection in many of the hospitals has not decreased appreciably, and the difficulty appears to lie with the admission of patients with undiagnosed tuberculosis.

It is undeniable that exposure to undiagnosed tuberculosis is high in many general hospitals. Autopsy studies reveal unsuspected tuberculosis in many older persons dying from other diseases. X-raying of admissions formerly presented a budgetary problem, but today the cost is considerably reduced by the use of miniature X-ray film. The cost to hospitals would probably be offset by the reduction in compensation paid to nurses who develop tuberculosis. It seems obvious that more attention should also be paid to such sources of infection as the autopsy room.

Considerable disagreement prevails over the degree of aseptic technique to be used when caring for the tuberculous patient. Complete isolationist technique is not always possible because many patients are ambulatory. Patients with arrested disease may occasionally produce positive sputum, and such persons can never be rehabilitated economically or socially if kept in isolation.

Many authorities believe that BCG is not the answer to protection since studies by them have shown no significant difference in morbidity between positive and negative reactors and because protection is not complete. All agree that the tuberculous patient should be isolated on separate wards in the general hospital.

Undoubtedly, technique should be stressed constantly in order that the nurse may not grow careless. It is probably true that many doctors serve as bad examples by not adhering to the technique which they themselves recommend. Some believe the tuberculin-negative student nurse should not be allowed to care for tuberculous patients, but this is hardly a practical suggestion.

It is quite generally agreed that BCG should be given the tuberculin nonreactor as an adjunct to preventive technique, particularly in situations where the tuberculous patient is noncooperative, as in the mentally deficient.

Although variations appear in the programs reported, the consensus seems to be that six months represent the maximum time which should be allowed to elapse between tuberculin testing or X-raying of hospital personnel.

Tuberculosis Among Hospital Personnel, Eleanor C. Connolly, M.P.H., National Tuberculosis Association, 1950.

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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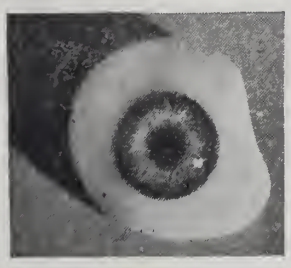

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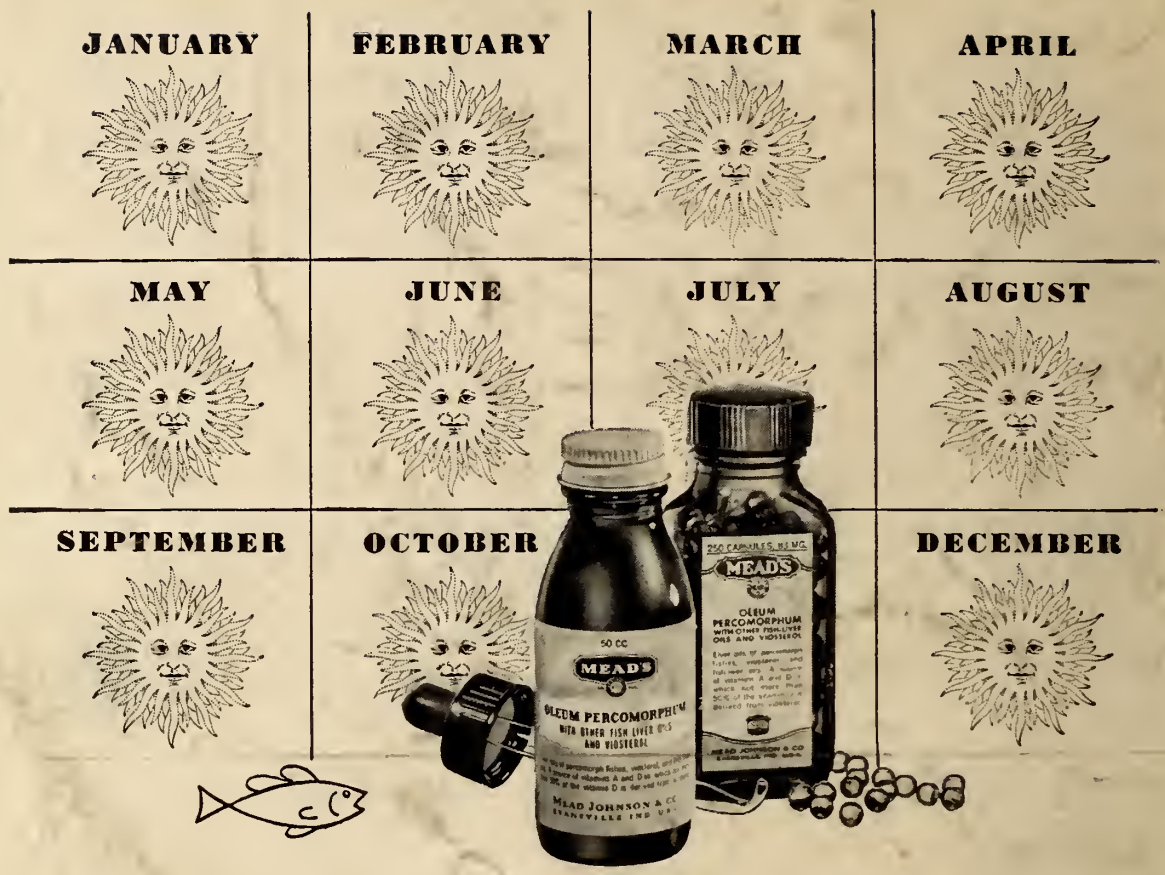

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CONTENTS—Pages 497 to 544

EDITORIALS— Page

President's Message: Intern, Intern, Who Gets the Intern? 497
Your Society Needs an Executive Officer ... 499
Speakers Bureau 499

ORIGINAL ARTICLES—

Intrapulmonary Hematoma Due to Non-penetrating Injury—Allen Welkind, M.D., Newark, N. J. 501
Low Dosage Potassium Thiocyanate in the Treatment of Hypertension — Aaron E. Parsonnet, M.D., Franklin Simon, M.D., and Arthur Bernstein, M.D., Newark, N. J. 504
Early Diagnosis of Cancer of the Stomach—Benjamin Copleman, M.D., Perth Amboy, N. J. 510
Pyloric Obstruction by a Cholelith—Andrew E. Ogden, M.D., Trenton, N. J. 512
Anesthesia for Gynecologic and Obstetrical Operations—Edward B. Tuohy, M.D., Washington, D. C. 514
Hemorrhagic Disorders—Sylvan E. Moolten, M.D., Highland Park, N. J. 517
Gas Bacillus Infection of Abdomen Following Appendectomy—William A. Cappiello, M.D., Emanuel Liccese, M.D., and William D. Crecca, M.D., Newark N. J. 519

ORIGINAL ARTICLES— Page

Malignancy in Gastric Ulcer—Louis L. Perkel, M.D., and Leonard Troast, M.D., Jersey City, N. J. 521
Antepartum Rupture of the Uterus — H. Oren, M.D., Park Ridge, N. J. 524
Removable Rubber Bandage Extension for the Extremities—Albert A. Schwartz, M.D., Perth Amboy, N. J. 526

STATE ACTIVITIES—

Course in Industrial Medicine 525
Resolution on the Death of James F. Norton, M.D. 527
Communication Chart for Aphasics 527
Who Is in the Reserves? 528
Shock Resulting from Burns 529
Welfare Committee Meeting 530
Trustees' Meeting 531
Supplementary List of Members No. 7 533
Industrial Medicine Lectures 533
Academy of Medicine Graduate Week 534

OBITUARIES 534
PUBLIC HEALTH NEWS 535
COUNTY SOCIETY REPORTS 536
WOMAN'S AUXILIARY 540
BOOK REVIEWS 541
TUBERCULOSIS ABSTRACTS 543

Roster of Officers and Committee Chairmen, Advertising Page 3A

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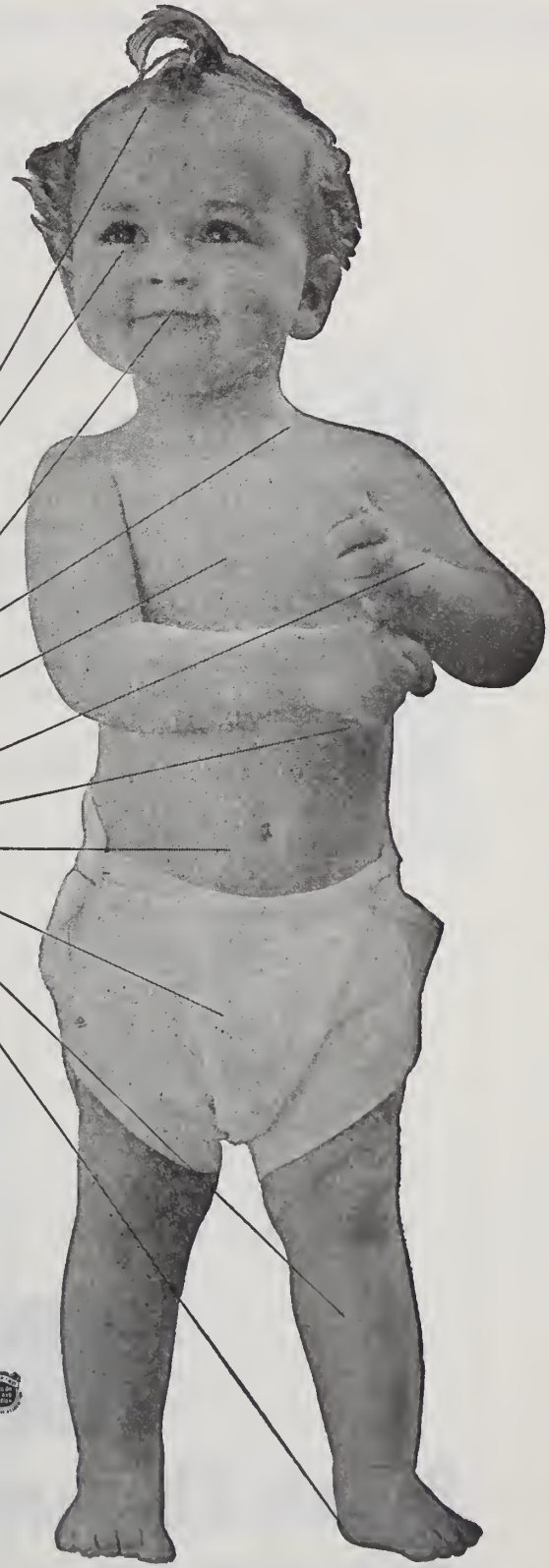

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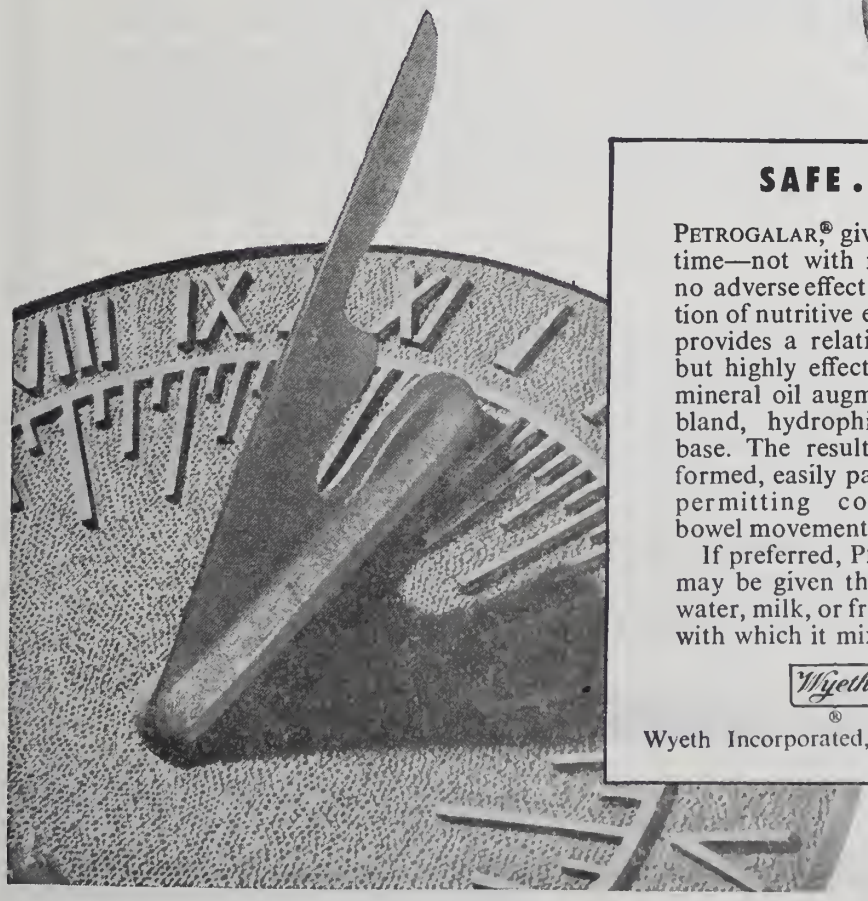

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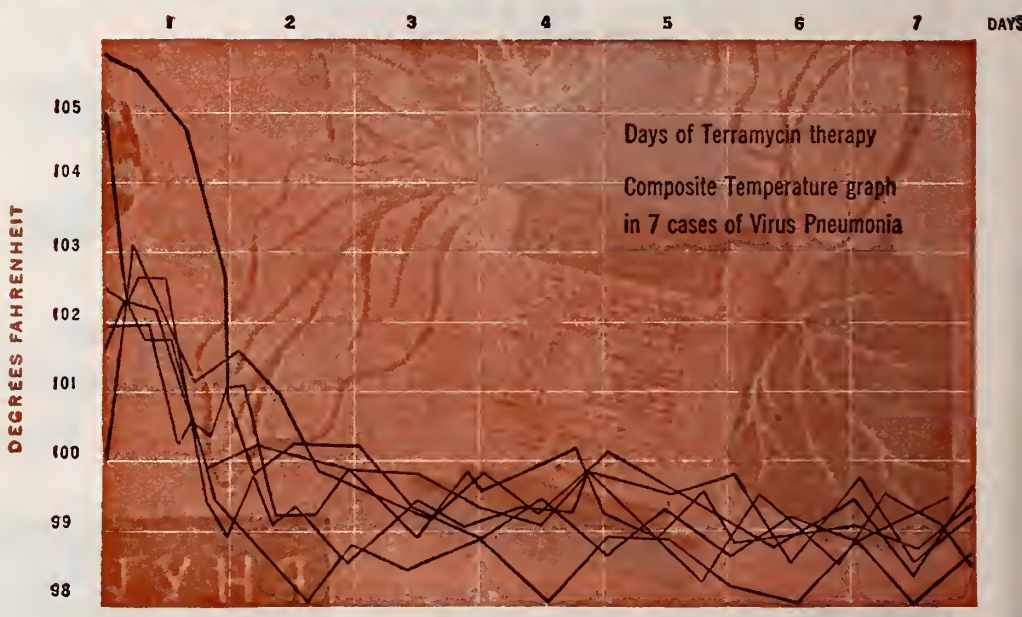

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1. *Blake, F. G.; Friou, G. J., and Wogner, R. R.; Yale J. Biol. and Med. 22:495 (July) 1950.*
2. *Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.*

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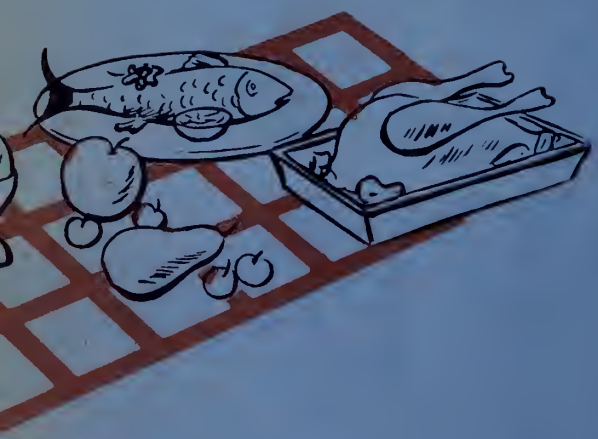

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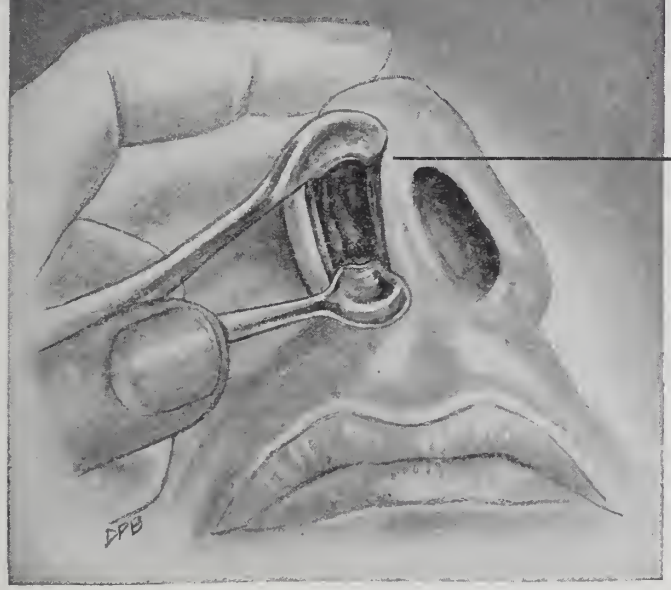
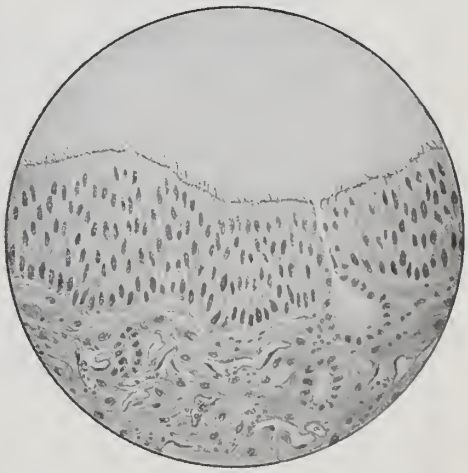


Nasal membrane showing increased leukocytes with denudation of cilia.

Normal appearing nasal epithelium.



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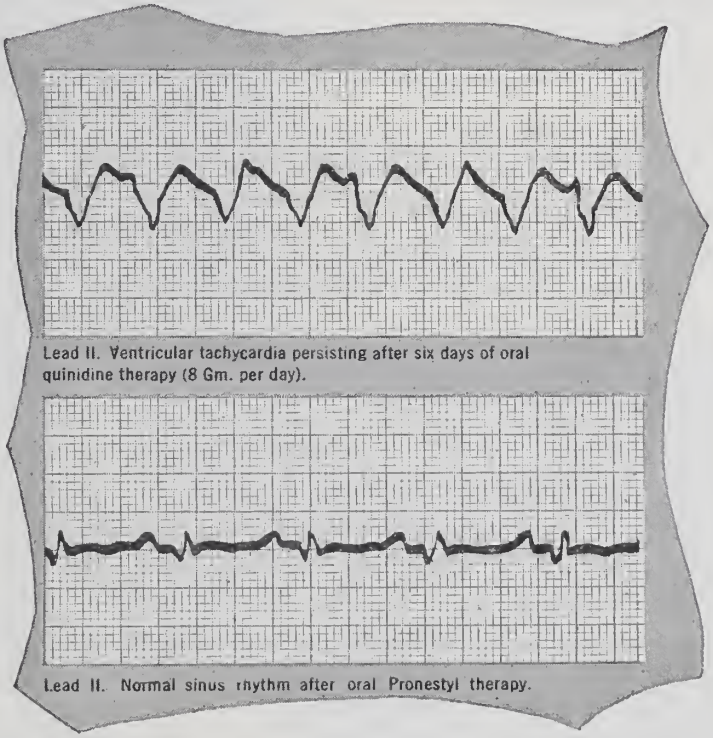
a new drug . . .
for the treatment of ventricular arrhythmias

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride



Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of blood count, urine, liver function, blood pressure, and electrocardiogram. Pronestyl may be given intravenously with relative safety.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
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The Only Form Of This Important Vitamin Official In The U. S. P.

PREFERRED BECAUSE

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Potency: Potency of this U.S.P. product is accurately determined by precise weight.

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Efficacy: Produces, in microgram dosage, maximum hematologic and neurologic effects.

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*Now you can confirm for yourself, Doctor, the results of the published studies**

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Take a puff – DON'T INHALE. Just s-l-o-w-l-y let the smoke come through your nose. AND NOW

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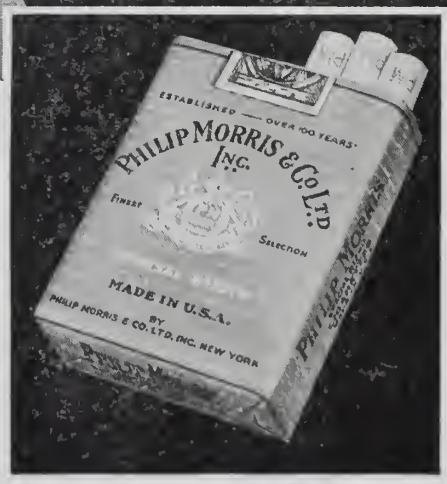

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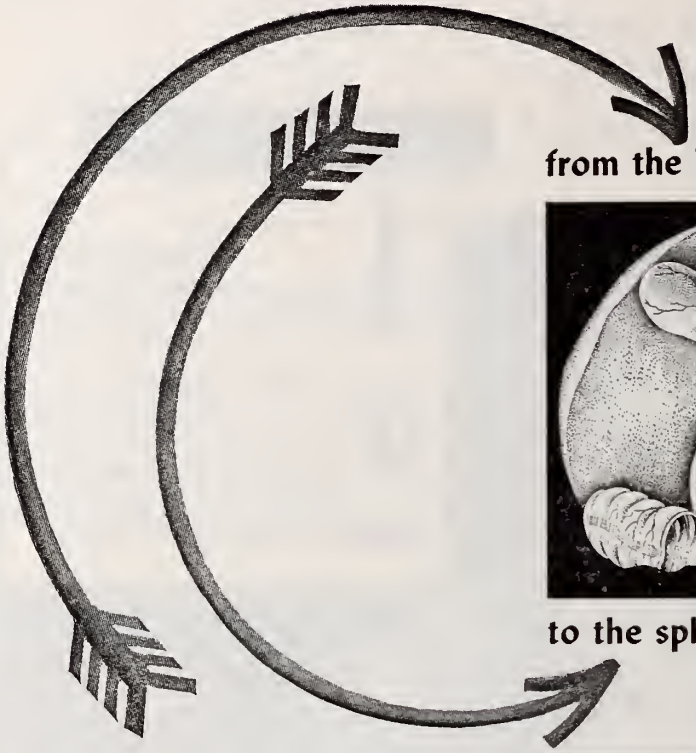
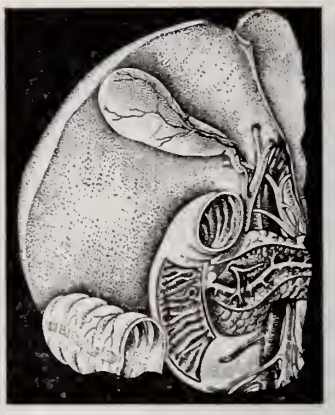
**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*



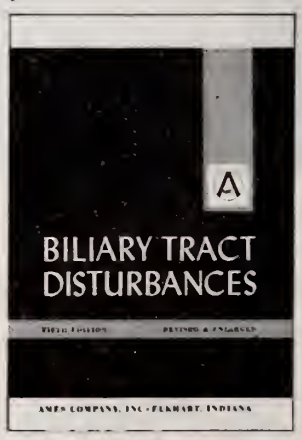
from the liver parenchyma



to the sphincter of Oddi

The area surveyed in the Fifth Edition of "Biliary Tract Disturbances," now available, is the entire, ramified biliary tree—its anatomic and physiologic background and the diagnosis and therapy of its disorders.

Physicians and surgeons acquainted with previous editions of this monograph will find the newly revised, enlarged and illustrated edition even more practical. The brochure concisely presents basic concepts of biliary tract disease, and reviews recent progress in the management of biliary disorders with hydrocholeretics and other measures. You may receive your copy on request from the Medical Department, Ames Company, Inc., Elkhart, Indiana.



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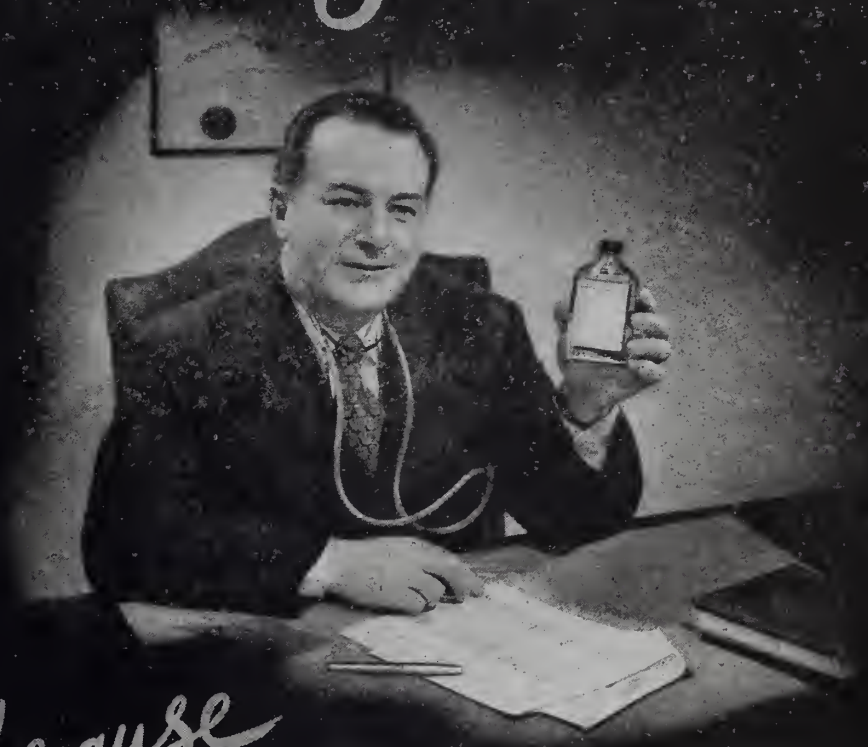

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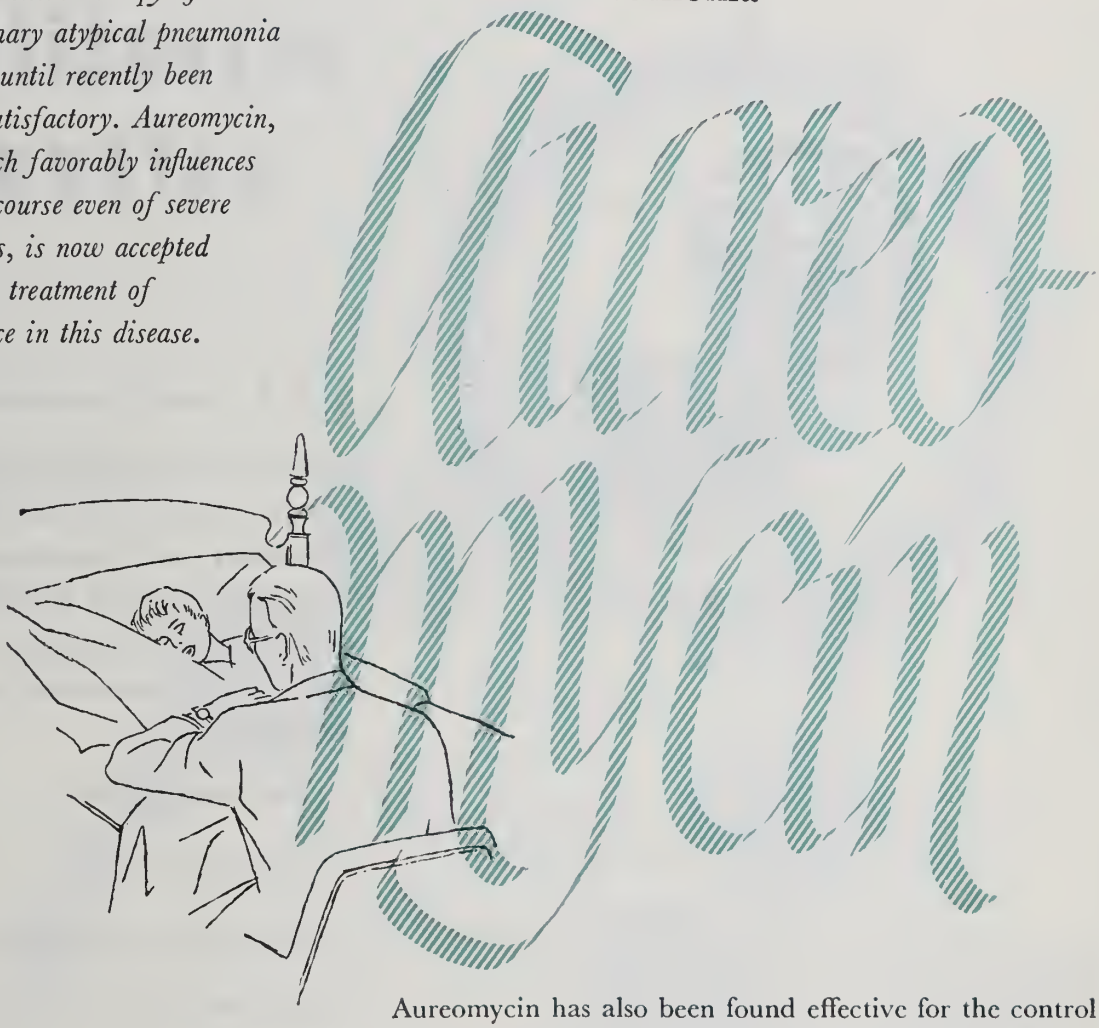

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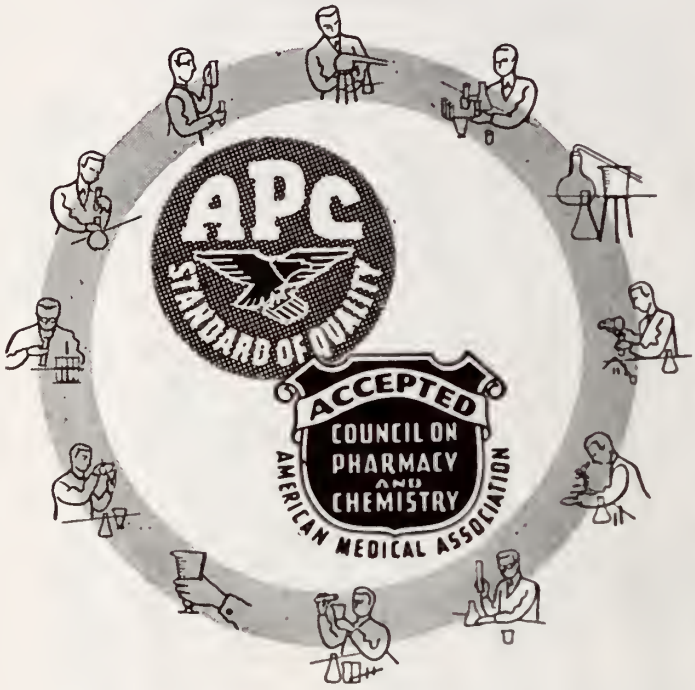

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- constant quality
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more physicians are satisfied

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And yet, for all these advantages, Biolac costs no more.

For *up-to-date*, complete infant nutrition, prescribe *new improved*

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Ingredients: skim milk, dextrins-maltose-dextrose, lactose, coconut oil, destearinated beef fat, lecithin, sodium alginate, disodium phosphate, ferric citrate, vitamin B_1, concentrate of vitamins A and D from fish liver oils, and water. Homogenized and sterilized.

Dilution: one fluid ounce to one and a half ounces of boiled water for each pound of body weight.

Biolac is available in 13 fluid ounce tins.

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A Real American Breakfast

That a nutritious breakfast providing generous amounts of high quality protein prevents late morning hypoglycemia has been amply demonstrated. As shown by Thorn and co-workers,[1] and later confirmed by Orent-Keiles,[2] ". . . breakfast high in protein and low in fat and carbohydrate was followed by an improved sense of well-being and no symptoms of hypoglycemia."

Meat for breakfast—ham, sausage, bacon, breakfast steaks—is an appetizing means of increasing the protein content of the morning meal. Its biologically complete protein contains all essential amino acids, and serves well in complementing less complete proteins from other sources. Furthermore, muscle meat is an outstanding source of B complex vitamins and of iron.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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PRIODAX cholecystograms can be accepted at face value. A diseased gallbladder visualizes faintly or not at all. With PRIODAX, a poor shadow means lack of ability to concentrate the contrast medium. Because PRIODAX is well tolerated, the likelihood of loss through the gastrointestinal tract by vomiting or diarrhea is minimal. Thus interpretation is made simpler and more certain.

PRIODAX®

(brand of iodoalphionic acid)

PRIODAX, Schering's brand of iodoalphionic acid, is available in tablets of 0.5 Gm. Envelopes of six tablets in boxes of 1, 5, 25 and 100 envelopes; and Hospital Dispensing Package containing 4 rolls of 250 tablets each.

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Use it in Sulfonamide Therapy

● Reactions ranging from mild antagonism to overt rebellion are to be expected when children are confronted with bad-tasting medicine. Contrast this with juvenile enthusiasm for DUOZINE *Dulcet* Tablets. Here's medicine that sweets-loving small fry (and many adults) really enjoy—sulfadiazine-sulfamerazine disguised in orange-colored, candy-flavored cubes.

Mothers find DUOZINE *Dulcet* Tablets easy to administer in exactly the prescribed dosage. You'll find them effective in many systemic infections. The combined sulfonamides are independently soluble in the urine, with the result that high blood levels can be maintained with small likelihood of crystalluria and renal damage.

DUOZINE *Dulcet* Tablets, sulfadiazine-sulfamerazine in equal parts, are available in 0.3-Gm. and 0.15-Gm. potencies, bottles of 100. Mighty "take-able" medication when sulfonamides are indicated. Abbott

See that the Rx reads

DUOZINE Dulcet® Tablets

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(SULFADIAZINE-SULFAMERAZINE COMBINED, ABBOTT)

®MEDICATED SUGAR TABLETS, ABBOTT

there is no age limit for nasal congestion

. . . nor is there any age when welcome relief is not safely obtained with Inhaler 'Forthane' (Methylhexamine, Lilly). Suffering from nasal congestion or risking annoying side-effects from a drug has often been the case. Since the advent of 'Forthane,' effective relief is normally afforded without:

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For protection as well as relief, physicians are suggesting that their patients keep Inhalers 'Forthane' on hand.

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Vol. 47, No. 11 — November, 1950 — Single Copies, 30 Cents; Subscriptions, $3.00 per Year

PRESIDENT'S MESSAGE: INTERN, INTERN, WHO GETS THE INTERN?

Every year some 5000 senior medical students look over the market and take their pick of the country's 8000 annual internship vacancies. That leaves many hospitals so undermanned that each intern has to fill two or three vacancies. How to stretch 5000 medical school seniors to cover the 8000 vacancies is worrying officials of small hospitals these days. Five methods are available:

1. *Reduce the number of approved internships.* The state licensing agencies might disaccredit some three thousand internships, thus reducing the vacancies each year to correspond to the number of senior students available. This solves the problem as neatly as cutting off a sleeper's feet to fit him to the bed. Justification would be that the failure of a hospital to obtain interns would automatically put it in a substandard class.

2. *Increase the number of medical students.* Any increase in the size of classes will mean a decline in the amount of teaching time given to each student —in other words a lowering of the quality of medical education. There seems little chance of this in the foreseeable future, unless the government goes in for large scale aid to schools, and insists on quantity production as a prerequisite to financial help. Not many new medical schools can be established because of the staggering cost of opening and operating a medical school today. A few extra interns may be obtained by speeding up the machinery for accrediting foreign schools.

3. *Double the length of the internship.* The average minimum internship today is twelve months. A two-year minimum would benefit everybody. The in-

terns would get better grounding in clinical practice. Patients would get more seasoned house physicians. Hospitals would solve their recruitment problem, because the annual number of vacancies would be sliced from 8000 to 4000. And with 5000 senior students competing for 4000 vacancies, the hospital intern committee could sing "Happy Days Are Here Again". However, this plan could not be effected piece-meal. It would have to be adopted all at once for the entire country. Otherwise, the little nonteaching hospital which has trouble getting an intern for one year would get no applicants at all if the service period were locally increased, while in other parts of the country one-year internships were still available. It seems unlikely that 49 licensing authorities would simultaneously adopt a two-year internship minimum. As a practical matter, however, the basic two-year internship *could* be established almost overnight if the A.M.A. would simply refuse to accredit any hospital which has an internship of under 24 months.

4. *Let the present situation remain.* A hospital has to offer the applicant one of three things: prestige, superior clinical teaching or more money. The more famous hospitals can get all the interns they need because of their prestige and teaching facilities. The other hospitals may have to "buy" intern services, perhaps by calling it a "general practice residency", thus justifying a higher-than-average salary. In this way, the present catch-as-catch-can system could go on indefinitely. Hospitals that have trouble getting interns could (a) hire ex-interns from other hospitals and pay them residents' salaries, or (b) use osteopaths, alumni of grade B schools or foreign graduates. The latter procedure might cost the institution its A.M.A. accreditation. But if they can't get interns, some hospitals might feel that the accreditation isn't worth having.

5. *Better allocation of the pool of senior students.* It is possible to compute the number of senior students and allow each hospital a quota based on admission rate or bed capacity. If this were done equitably, many of the 8000 internship berths would vanish at once. This is because some hospitals ask for, and get, more interns than they need. If the hospital has enough prestige, it can attract many young doctors willing to furnish low-cost labor to the institution in return for the glamor of association with famous names. The more prestige the hospital enjoys, the easier it finds it to recruit interns—and the greater the temptation to pad the house staff. From a rational view point, a central allocating agency would seem to be the best solution. Such an agency could allot the proper number of interns, without actually assigning them by name to specific hospitals. There is, of course, some risk that this agency would be effectively dominated by officials of teaching hospitals, since these officials are the ones who catapult to leadership in almost any new medical or hospital project. It would be hard for them to be absolutely objective about the needs of *all* hospitals. They would want a rigid yardstick to measure the intern quota for each institution. One possible criterion would be the total number of beds; or, better, a formula which weighted ward beds more heavily than private rooms. Another factor could be the number of admissions.

The smaller community hospitals have few champions in this enterprise. They need interns badly but seem unable to compete with the more famous institutions, and the increasing shortage of house staff personnel leads to undesirable improvisations. The loudest voices in medical and hospital circles naturally belong to the most famous of the institutions. Where will the smaller, nonteaching hospitals find their spokesmen?

Aldrich C. Crowe, M.D.

YOUR SOCIETY NEEDS AN EXECUTIVE OFFICER

The position of Executive Officer of our Society is now vacant. Applications are being received. For obvious reasons it is especially desirable to have a member of the Society serve as Executive Officer. Any member interested in this vacancy may communicate directly with Dr. Sigurd W. Johnsen, Chairman of the special committee. Dr. Johnsen's address is 149 Prospect Street, Passaic. The other members of the committee are Dr. Harrold A. Murray and Dr. Henry B. Decker, and communications may be addressed to either of them if this is more convenient.

At the last meeting of the Board of Trustees, our Executive Officer, James E. Bryan, asked to be relieved of his duties to accept appointment as administrator of the Medical-Surgical Plan. By unanimous vote the Board expressed to Mr. Bryan its appreciation for the excellent service he has given the Society during the last three years and accepted his resignation with regret. Mr. Bryan enters his new duties with the assurance he will have the active cooperation of the profession and best wishes for success to spur him on.

The field of medical administration is a rapidly growing one and physicians are losing their old-time fear of being involved in public relations and in office management. It seems certain that in the years to come health insurance plans will grow rapidly so that there will be increasing demand for doctors who are experienced in administration. The position as Executive Officer of a medical society calls for interest in public relations and general administration. An Executive Officer is expected to do a fair amount of public speaking, copywriting and meeting with people. He must combine firmness and decisiveness on one hand with diplomacy and poise on the other. Such a quartet of virtues should not be beyond reach and it is hoped that somewhere among our members, if possible, a qualified Executive Officer may be found.

THE SPEAKERS BUREAU

To bring the skills of public relations to the peak of fruition, every vehicle of sound approach is needed. One of the most helpful media is a smooth functioning Speakers Bureau. The busy practitioner tends to leave the public speaking job to the other fellow—to the society official or to a paid representative. The doctor too often thinks of himself as an indifferent public speaker, harassed by busy afternoon and evening hours, and "unable" to mount the platform in his own right.

Truth is, however, that the individual doctor is the number 1 ambassador of good will between the organized profession and the general public. Many doctors give papers at staff and society meetings and are adequately at home on the speaker's dais. Even where the physician is not a good "orator" he is still the best speaker because what he may lack in formal oratorical technic, he more than makes up in sincerity, status and grasp of his subject.

Every doctor who is not working with his county society's Speakers Bureau should ask himself why not? As an instance of how much can be accomplished by a lively Speakers Bureau, look at the record in Essex County. In the last fiscal year, this busy Bureau furnished speak-

ers who, in the aggregate, held the platform for a total of over 300 hours in one season. They spoke on radio, before television, and in auditoria. They addressed high schools, labor unions, colleges, and civic groups. They spoke as representatives of their county society, and on numerous occasions in coordination with other groups. They spoke on cancer and on compulsory health insurance. They participated in fifty formal or informal debates on the latter topic. They spoke on geriatrics and pediatrics, on drug therapy and on gynecology. They delivered lectures, moderated discussions, participated in debates, chaired general meetings and served as parts of panels. They met all commitments for series of lectures—for example, ten talks (to the adult schools) on "what's new in medicine", or twelve weekly television appearances on the "Know Your Doctor" program.

This impressive score was rolled up by a tireless Speakers Bureau under the chairmanship of Dr. Forte and under the general supervision of Dr. Murray's county Public Relations Committee. Of course, the contribution of the practitioner-speaker was the most vital part of the project. But behind the scenes, the committee labored to handle program details, edit speeches when requested, worry about transportation, (often about lighting and platform facilities, too), arrange for publicity and manage the countless other chores which are as essential to the smooth operation of the Bureau as oil is to an engine.

Nor was Essex County alone. Many other county medical societies have livewire bureaus. All of them have one complaint: too many members take the position that a Speakers Bureau is fine, but that the other fellow should do the speaking. "I'm too busy . . . or too inexperienced in public speaking" were the major excuses for nonparticipation.

It is customary to plead with doctors to serve on a county society Speakers Bureau by arguing that this is a duty which he owes to organized medicine. Actually it is more than that. It is a duty he owes to himself. And for those whose touchstone is "What's in it for me?" there is an answer. Even the most maladroit speaker eventually acquires ease and poise after he has taken the platform often enough. The skill thus acquired is of inestimable value to any professional man. There is always something embarrassing about the physician who can not face an audience. Furthermore, it is always the really busy man who manages to find time for civic and organizational activities. Experience in public speaking is acquired only by doing the speaking. It's an experience that never hurt anyone.

ORIGINAL ARTICLES

INTRAPULMONARY HEMATOMA DUE TO NON-PENETRATING INJURY *

REPORT OF A CASE

Allen Welkind, M.D., Newark, N. J.

The tempo of modern living has resulted in a constantly rising rate of lung injury. Automobile, aviation, industrial and farm accidents are the major contributors in civilian practice. The average surgeon is familiar with traumatic pneumothorax, hemothorax, subcutaneous and mediastinal emphysema, et cetera. The recent wars added much to our knowledge. In both peace and war the usual cases encountered show extensive involvement with high mortality. A few years ago I followed the clinical course of a lung injury which was relatively minor and made an uneventful recovery. Certain aspects were bizarre and raised questions which required answers not obtainable from the literature or standard texts. Although the literature is replete with reports of all sorts of pulmonary damage only a few references have been found which describe isolated pulmonary hematoma. None show a course which can be likened to the one to be presented here.

The patient, a 37 year old male, an assistant in an electrical research laboratory was referred for examination on March 3, 1947. He had first consulted his family physician on the preceding day. He gave a history of having had a skiing accident two weeks before. An expert skier, he had run into a tree to avoid colliding with another skier on a downhill run. Travelling at a high rate of speed he struck the tree a glancing blow with his entire right side. He was unconscious when reached by others. When revived he complained of severe pain in the right chest, made worse by breathing. He was dyspneic, coughing, and (on two occasions on the same day) he expectorated small quantities of bright red, frothy blood. A local physician strapped his chest and gave him an opiate which relieved his pain. Although there was still considerable discomfort the following day he was able to sit up in bed. Dyspnea had abated but cough continued, and was productive of blood tinged sputum for the next three days. He felt somewhat "feverish" for a few days, but improved sufficiently to return from Vermont (where the accident occurred) to New Jersey. In the succeeding ten days his only complaint was persistent pain in the right chest increased by breathing, severe enough to cause him to seek medical help.

On examination the only findings of note were: temperature was 98.2, pulse 84, respirations 19. There was no cyanosis. He did not appear ill. There was a large fading ecchymotic area over the right axilla, and a smaller one over the lateral aspect of the right thigh. All the ribs showed tenderness on pressure in the axillary region. No crepitation was elicited. Pressure on the sternum revealed no localizing pain. There was slight limitation of motion of the right thoracic wall. Palpitation, percussion and auscultation were within normal limits, except for a few wheezing rhonchi in the anterior axilla on the affected side. These were transient, and cleared on cough. No other positive findings were noted.

Figure 1.

Fluoroscopy showed that the heart was in the midline and suffered no chamber enlargement. The diaphragms were of normal contour and moved

* Presented to the Chest Conference, Newark Beth Israel Hospital, May 1948. Dr. Welkind is Adjunct Physician to the Newark (N. J.) Beth Israel Hospital.

freely and equally. The bony cage showed no gross deviation from normal. Lung fields were clear except for the right middle lobe which exhibited a tumor-like shadow consisting of two spindle shaped masses which fused at their axillary ends. Each was about 2.5 centimeters long and 15 millimeters at their thickest. Lateral and oblique views localized the lesion to the right middle lobe, just below the fissure. There was no involvement or extension into the fissure. X-ray (Fig. 1—retouched) showed no other abnormalities. There was nothing to indicate involvement of the pleura either on fluoroscopy or x-ray, but because of increase in pain on respiratory movement, cough or laughing it had to be assumed that there was a pleuritic reaction, probably in the interlobar fissure. Strapping relieved the pain almost completely. By the end of the fifth week there were no residual symptoms. The x-ray changes very slowly resolved. At the end of twelve weeks the two joined spindles appeared to have separated, had become globular, and about half the previous size. Further resolution continued at a very slow pace. It was not

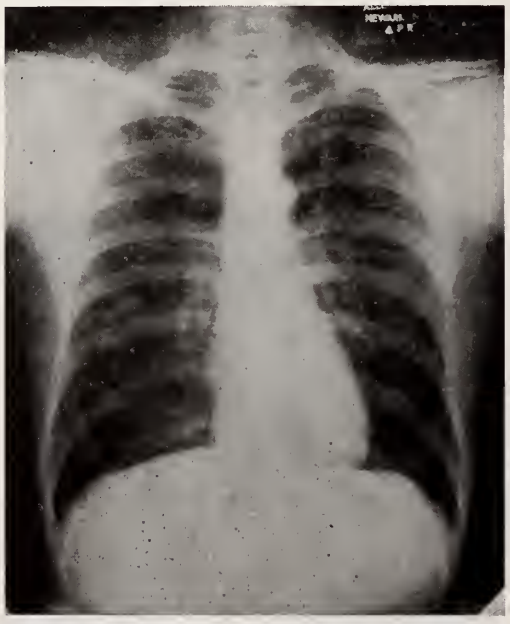

Figure 2.

until thirteen months after the injury that no further change was found. At this time all that remained were two persistent linear scars (Fig. 2) resembling the x-ray end result of infarction.

A diagnosis of intrapulmonary hematoma was made when he was referred to me. There was no x-ray evidence of fractured ribs. There was nothing to indicate pneumothorax. The right costophrenic sinus showed no fluid or other pleuritic reaction such as thickening. One may assume that the lung suffered a parenchymal injury without tear of the pleura. It was unfortunate that he had not been fluoroscoped immediately following the injury. The physician in Vermont did not fluoroscope nor x-ray the chest. In the differential diagnosis, strongest evidence was in favor of pulmonary hematoma or interlobar encapsulation of blood. The latter cannot entirely be ruled out. However if this were a bloody or serosanguineous effusion in the interlobar fissure one might expect roentgen evidence of pleural thickening along the adjacent portions of the fissures. This was not present. Not infrequently blood in the pleura is productive of calcification. In a three year follow-up the fissure has never showed this.

That the patient expectorated blood for five days following the injury is strong proof of disruption of lung tissue. The question of localized atelectasis due to accumulated and clotted blood in the bronchioli must be considered. However, it would be a most unusual course for such atelectasis *per se*.

The standard texts and literature offered some help. Rubin[1] mentions hematoma of the lung following crushing injuries. The lung may be lacerated without pleural tear. Blood accumulates in the tear and forms a hemotoma. The lesion is described as globular. Wessler and Jaches[2] do not describe it, although Wessler[3] states that he has seen the lesion a few times, and that it was invariably spindle shaped. Graham, Singer and Ballon[4] mention intrapulmonary bleeding due to trauma but do not include hematoma as a separate entity. Sante[5] describes penetrating wounds of the lung with bleeding into the parenchyma but does not describe the nonpenetrating laceration without pleural involvement. Thoracic "concussion" according to Dolley and Brewer[6] produces changes in the lung of petechial type like that of cerebral concussion. Other changes seen are traumatic atelectasis and pneumonitis.

1. Rubin, E. H.: Diseases of the Chest, W. B. Saunders Co., Philadelphia, (1947).

2. Wessler, H., and Jaches, L.: Clinical Roentgenology of Diseases of the Chest. Southworth Company, Troy, N. Y. (1923).

3. Wessler, H.: Personal communication.

4. Graham, E., Singer, J. J., and Ballon, H. C.: Surgical Diseases of the Chest, Lea and Febiger, Philadelpha (1935).

5. Sante, L. R.: Principles of Roentgenological Interpretation, Edwards Bros., Inc., Ann Arbor, Michigan (1949).

6. Dolley, F. S., and Brewer, L. A., III: Annals of Surgery, 116:668 (1942).

Phillips[7] and Parker[8] also have seen pneumonitis following non-penetrating trauma. Blair,[9] in a study of thoracico-abdominal war injuries, records cases of pulmonary hematoma. One x-ray reproduction shows a circular mass off the right hilum which was "fuzzy" at the periphery. It was his experience that they completely resolved after six to eight weeks. No follow-up studies were given. McGrigor and Samuel[10] found hematoma following blast or non-penetrating contusions. Their cases were central unilateral opacities with poorly defined borders and were occasionally so large as to obscure one hemithorax. They specifically pointed out that the pathology was obscure and that resolution took as long as six to eight weeks. Again the course was not discussed. The spindle shape of the hematoma reported in this paper was also seen by Savage[11] who in a large series of blast injury cases saw two with similar pulmonary lesions.

Nowhere was any description found of the pathologic changes. Apparently uncomplicated cases of hematoma all recover. No information could be gathered from postmortem studies on cases of blast lung by Zuckerman,[12] or Tunbridge and Wilson.[13] Here the usual findings are disruption of alveoli and alveolar capillaries with exudation of blood and serum into the air spaces and interstitial tissues. This bleeding may be extensive enough to involve one or more entire lobes, and is almost invariably bilateral. In no case was there gross laceration of the parenchyma. Wilson and Tunbridge[13] reported one case that showed bronchiolar rupture. King and Curtis[14] describe lung contusion with tears and internal bleeding. Martland[15] has seen similar injuries in children injured by automobiles. Most often the entire lobe is ruptured through the pleura. Occasionally internal rupture is seen. When this is present there is accumulated blood within the pocket. Bronchi, blood vessels, and parenchyma are all torn. Martland's experience as a medical examiner in a heavily populated metropolitan area is with accidental death, and has not afforded opportunity to see progressive or late changes.

In comparing my case with those of Blair,[9] and McGrigor and Samuel[10] one major difference is seen. The period of resolution of their cases was six to eight weeks. It was thirteen months before roentgen findings showed no further change in the case reported here. It is inconceivable that a simple hematoma would take thirteen months completely to resorb. It is possible that some sort of thick capsule formed around the clotted blood, retarding the resolution. Since we have some evidence that blood vessels were ruptured one may expect the lung tissue peripheral to the laceration responded like a hemorrhagic infarct. Hampton and Castleman,[16] and Castleman,[17] in their classic study of pulmonary infarction showed that there are various shapes taken by these lesions, among which is this spindle form. Also, after healing is complete, a platelike area of atelectasis remains. His x-ray findings were those seen in my case. It is likely that the answer to the question is therefore a combination of hematoma and infarction. Final solution of the problem can come only from postmortem studies of hematoma months or years after injury.

CONCLUSIONS

1. A case of lung injury due to non-penetrating trauma is reported. The final diagnosis was internal laceration of the lung with hematoma. Resolution extended for over a year. The reason was not apparent.

2. The possibility of infarction as a cause of the lung period of healing was offered.

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7. Phillips, E.: Journal of the American Medical Association, 133:161 (January 18, 1947).
8. Parker, E. F.: Journal of the South Carolina Med. Association, 36:219 (Aug. 1940).
9. Blair, L. G.: British Journal of Radiology, 18:258 (August 1945).
10. McGrigor, D. B., and Samuel, E.: British Journal Radiology, 18:133 (May 1945).
11. Savage, O.: Lancet, 1:424 (April 7, 1945).
12. Zuckerman, S.: Lancet, 2:219 (August 24, 1940).
13. Wilson, J. V., and Tunbridge, R. E.: Lancet, 1:257 (February 27, 1943).
14. King, J. D., and Curtis, G. M.: Surgery, Gynecology and Obstetrics, 74:53 (January 1942).
15. Martland, H.: Personal communication to the author.
16. Hampton, A. O., and Castleman, B.: American Journal of Roentgenology, 43:305 (March 1940).
17. Castleman, B.: Archives of Pathology, 30:130 (July 1940).

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LOW DOSAGE POTASSIUM THIOCYANATE IN THE TREATMENT OF HYPERTENSION *

AARON E. PARSONNET,† M.D., FRANKLIN SIMON, M.D., and
ARTHUR BERNSTEIN, M.D., Newark, N. J.

When the treatment of essential hypertension is discussed these days, the blood pressure of the investigators emulates that of their patients as a result of intense partisan adherence to one or another of the schools of therapy. Essentially there are now five schools of thought, as has been so ably brought out in a recent article by Goldring.[1] The first group feels no therapy for hypertension is indicated at the present time until the cause is determined and specific therapy can be directed towards a specific etiologic agent. The next three groups agree that essential hypertension should be treated and the blood pressure lowered even though we cannot prove that this is necessary or desirable. However, they differ in what they consider to be the proper therapy for accomplishing this end. The first of these three groups uses one of the many drugs that have been advocated: (1) barbiturates, (2) niacin, (3) thiocyanate CNS, (4) xanthines, et cetera (just to mention a few). Next are the dietotherapy advocates, and fourth are the adherents of sympathectomy, the surgeons, who form a vociferous group. The last school is similar in many respects to the first or "hands off" group in that they prescribe no medication but do advocate and practice psychotherapy.* *

We have always belonged in that group that feels that even though we do not know the cause of hypertension there is something to be gained by lowering the blood pressure. We feel with others,[2] that by lowering the blood pressure, we stave off a rapidly progressing arteriolar sclerosis, cardiac enlargement and heart failure. Therefore, we were very much interested in the use of a new preparation combining several drugs long used in the treatment of hypertension. This preparation,‡ a sugar-coated tablet containing potassium thiocyanate (48.7 milligrams), sodium nitrite (32.5 milligrams), Rutin (10 milligrams), and pentobarbital-sodium (16.2 milligrams), had apparently two advantages over the preparations we had been using previously. It combined in one single simple tablet three drugs which had been used extensively in the treatment of hypertension: pentobarbital, sodium nitrite and thiocyanate. And, if the amount of thiocyanate present in this preparation was truly effective, the blood levels would be below the toxic levels so that one of the chief objections to the use of thiocyanate for hypertension would be considerably reduced. However, as stated by Barker,[3] toxic effects of thiocyanate have been reported at serum levels far below the so-called toxic range and toxic levels may be attained with small doses of the drug if the urinary excretion of thiocyanate is impaired.

Let us then examine the drugs which are in combination in this formula and discuss briefly their place in the treatment of hypertension. The action of the *nitrites* in dilating the arteries by depressing the muscle of the wall and their action in dilating the post arteriolar vascular bed is a well-established pharmacologic fact. Nitrites lower the systolic blood pressure more than the diastolic both in normal and in hypertensive patients diminishing the pulse pressure. Sodium nitrite begins its action within five minutes after ingestion and acts for about one to two hours. Toxic effects (methemoglobinemia, headaches, syncope, gastric irritation, et cetera) are not likely in the dose employed. *Pentobarbital-sodium* has been so widely used that it would be redundant to more than mention it in passing. It falls into the group of barbiturates which act for a moderate length of time with rather rapid detoxification in the liver and excretion via the kidney.

The use of *thiocyanate* and its action on the blood pressure has been the subject of violent disagreement. The thiocyanate ion acts similarly to both

† Dr. Parsonnet died on August 20, 1950.

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* * It seems to us that psychotherapy is a specific form of treatment, and its advocates can hardly be classed with Group I, which advocates no therapy at all—Editor.

‡ Tablets *Turased* furnished through the courtesy of the E. L. Patch Co., Boston, Mass.

1. Goldring, W.: American Journal of Medicine, 4:875 (June 1948).
2. Petersen, D. M.: Journal of the Missouri State Medical Association, 40:279, (September 1943); *and* Blumenthal, J. S., and Wetherby, M.: Minnesota Medicine, 27:177 (March 1944).
3. Barker, M. H.: Journal of the American Medical Association, 106:762 (March 1936).

the iodides and the nitrites. Acting like the nitrites, it is capable of relaxing smooth muscle and apparently it is this action of thiocyanate that is utilized in the treatment of hypertension. Treupel and Edinger[4] in 1900 and Pauli[5] in 1903 first recommended thiocyanate in the therapy of hypertension. However, it was not until Barker[3] wrote his article on the use of the drug and described a method of determining the serum thiocyanate level, that it began to have a definite place in the therapy of hypertension. Thiocyanates can produce toxic reactions. In fact, from reading the literature, one would believe that everyone taking the drug has evidence of toxicity, even though in our own experience and in the experience of those who have had considerable contact with it, the incidence of toxic reactions is small.

Finally, Rutin has been added to this formula. Rutin, a flavone glucoside, has the property of decreasing capillary fragility (Griffith[6]) in subjects in whom this fragility is initially increased. Thiocyanate, as one of its side actions has a tendency to increase capillary fragility; hence the Rutin in the formula should counteract this effect. We must frankly admit that there may be some objection to this statement since the actual effectiveness of this drug has not yet been established beyond doubt.[7] However, there is certainly a theoretical logic in its inclusion in the combination. We have then a preparation containing three drugs commonly used in the treatment of hypertension combined in a formula designed for ease of administration, maximal effectiveness and possible potentiation of effects. Though it is true that the tendency in modern therapeutics is to use one specific drug for therapy, we feel justified in combining a group of drugs with some effectiveness in the hope of obtaining a total effect greater than that which can be obtained by any one of the individual drugs. With these facts in mind let us examine our results.

For this study, a group of 24 patients who have been followed by us for two years or longer with the diagnosis of essential hypertension was chosen. During the years they were under our care numerous observations of the blood pressure were made. During this interval of time and, of course, prior to starting this new combination of drugs, these patients were treated with many other "accepted" forms of therapy, as will be noted in the first table. Many patients had previously been on more than one type of therapy. This group of 24 patients best suited our purpose for two distinct and important reasons: (1) having been followed as regular patients for at least two years, we know rather well their average blood pressure readings prior to any form of therapy and during the intervals between different attempts at therapy; and (2) having had these same patients on one or more other therapeutic regimes, we could compare our previous results in blood pressure changes and subjective complaints with our results as obtained now with the newer combination. In all cases the possibility of unilateral renal disease had been ruled out. Gothlin indices were determined on all patients before initiating the therapy. A positive test was found in none of them. This group of patients can be considered to be an adequately controlled one since they had all been observed for a long period and had been on various forms of therapy during this time. This would tend to rule out psychogenic effects of this new therapy since its efficacy was being compared to other "new therapies" used in the past. Furthermore, the sedative effect of the phenobarbital could also be properly evaluated since these patients had all had this form of sedation for various periods of time. So, though the "blind test" method has certain advantages, we feel that this group could be properly evaluated because we had been following them for so long and on so many therapies. Furthermore, on the placebo therapy which was used, blood pressure rose at once.

All blood pressures were taken weekly with the patient seated, under constant conditions of preliminary rest, by one or the other of two of the investigators, in the morning when the patient had had no medication for at least 12 hours. Thus, one element of error was eliminated; namely, the recording of the short acting hypotensive effect of the nitrites rather than the overall effectiveness of this preparation as a unit for sustained therapy. The group consisted of 13 males and 11 females ranging in age from 20 to 67. All patients for the purpose of this experiment were given two tablets of the test preparation three times a day except for Cases 12 and 19, who received higher dosage because of a failure to obtain a thiocyanate level above two milligrams per cent on

4. Treupel, G., and Edinger, A.: Muenchner Medizinische Wochenschrift, 47:767 (1900).
5. Pauli, W.: Muenchner Medizinische Wochenschritt, 50:153 (1903).
6. Griffith, J. Q. *et al.*: Proceedings of the Society for Experimental Biology and Medicine, 55:228 (March 1944).
7. Report of the Council on Pharmacy and Chemistry, in Journal of the American Medical Association, 131:743 (June 29, 1946).

Case	Sex-Age	Duration of HBP (Years)	Average Before Therapy B.P.	Average After Therapy B.P.	Millimeter Reduction Average	Observation (Weeks)	Effect on Subjective Symptoms	Blood KCN Level	Tablets Daily Dose	Average B.P. on Previous Treatment	Previous Treatment	Turased Therapy Compared with Previous Treatment
1.	M 53	2	200/110	150/80	50/30	23	I	4.5	6	180/110	P	B
2.	M 67	10+	250/140	230/130	20/10	23	U	8.5	6	250/140	P	B
3.	M 39	6	220/120	170/95	50/25	25	I	5.0	6	?	?	?
4.	M 57	5	190/110	170/100	20/10	25	I	5.0	6	170/100	P, Na	E
5.	M 41	3	190/110	170/90	20/20	16	U	5.5	6	190/110	Na	B
6.	F 51	10+	180/100	140/80	40/20	25	I	9.6	6	180/100	P	B
7.	M 29	8	160/100	135/85	25/15	18	I	3.5	6	?	?	?
8.	F 60	15+	240/110	90/100	50/10	21	I	10.5	4	240/110	P	B
9.	F 53	15+	220/110	170/100	50/10	50	I	5.5	6	175/100	P. R. CN	B
10.	M 50	6	200/120	200/120	0/0	18	U	7.0	6	200/120	P, CN	E
11.	F 48	8	200/120	170/105	30/15	51	I	3.5	6	200/120	P	B
12.	F 43	4	200/115	170/105	30/10	21	I	2.0	8	200/110	P	B
13.	M 55	3	180/100	155/90	25/10	21	I	3.5	6	180/100	CN	B
14.	F 56	12	210/130	180/110	30/20	21	U	4.5	6	210/130	P, CN	B

Case	Sex-Age	Duration of HBP (Years)	Average Before Therapy B.P.	Average After Therapy B.P.	Millimeter Reduction Average	Observation (Weeks)	Effect on Subjective Symptoms	Blood KCN Level	Tablets Daily Dose	Average B.P. on Previous Treatment	Previous Treatment	Turased Therapy Compared with Previous Treatment
15.	F 40	2	195/110	60/90	25 — 20	13	I	4.0	6	140/80	Na	W
16.	M 47	2	190/110	170/105	20 — 5	18	U	6.0	6	180/105	P	E
17.	M 52	16	200/110	150/90	50 — 20	45	I	4.5	6	180/110	P	B
18.	M 42	6	160/115	70/110	+10 — 5	16	W	4.0	6	145/90	P	W
19.	M 59	20+	220/110	180/100	40 — 10	44	I	5.0	9	220/110	P	B
20.	F 36	7	160/105	140/90	20 — 15	42	I	5.0	6	155/105	P	B
21.	F 52	18	260/90	200/80	60 — 10	19	U	11.5	6	260/90	P	B
22.	M 20	4	170/110	150/90	20 — 20	18	U	8.5	6	160/110	Na	B
23.	F 28	3	180/120	185/105	0 — 10	16	U	2.0	6	160/110	Na	E
24.	F 37	4	190/120	155/105	35 — 15	8	I	4.0	6	180/110	Na	B

TABLE 1—EFFECTS OF TURASED ON BLOOD PRESSURE AND ON SUBJECTIVE SYMPTOMS

Abbreviations used in this table:

B—Better
CN—Thiocyanate
E—Equal
I—Improved
Na—Low sodium diet
P—Barbiturates, xanthines
R—Rice diet
U—Unimproved
W—Worse

the original dosage. Four subjects, as will be indicated below, were given placebo medication for variable lengths of time. The placebo used was a sugar-coated tablet containing lactose and was the exact replica of the therapeutic tablet. Blood was obtained by venipuncture at weekly and then bi-weekly intervals for thiocyanate serum level determination, even when the patients were on placebo therapy. A modified Schreiber technic was used for this determination.

TABLE 2—EFFECTS OF INSTITUTING PLACEBO MEDICATION IN PATIENTS ON TURASED THERAPY

Case	B.P. Before Turased	B.P. on Turased	Placebo given (weeks)	B.P. with Placebo
7	160/100	130/80	2	154/90
9	220/110	170/100	8	210/110
11	200/120	170/110	6	220/130
17	200/120	150/90	4	180/110

In all four subjects, the subjective improvement noted under Turased therapy was quickly lost on the placebo regime. The hypotensive effect and subjective improvement were quickly noted after re-initiating Turased medication.

DISCUSSION

Based upon the results as seen in Table I, we observe that Turased‡ was effective in reducing blood pressure in 19 out of 24 subjects, that is 79 per cent. Certainly the hypotensive effect would appear to have occurred at a "therapeutic" level of potassium thiocyanate and not at the "toxic" blood level as many authors have hinted. In judging improvement in blood pressure, an average reduction of at least 30 millimeters systolic and 15 millimeters diastolic was considered *good*. A reduction of at least 20 millimeters systolic and 10 millimeters diastolic was considered *fair*. On this basis, good response was obtained in eleven patients and fair in eight patients. This particular group of cases cannot be criticized from the point of view of not having been followed long enough before therapy was begun; nor can it be said that no other form of therapy was tried. Certainly the possibility of spontaneous remission is also very remote under the circumstances. Furthermore, in almost all of these cases, the barbiturates had been used without effective results so that we may definitely say that this new formula has an advantage over barbiturate therapy *per se*. Again, four of these patients had previously received thiocyanate therapy alone with equal or poorer results but with thiocyanate levels much higher than those needed to produce effective lowering of blood pressure as with this preparation. This increased margin of safety is highly desirable. On thiocyanate therapy alone, very little, if any, hypotensive effect was demonstrated at comparable thiocyanate levels, which suggests some potentiating action in the combination of drugs used. The hope expressed earlier in this report that we would not run into any marked elevation of thiocyanate levels or toxic reactions, was not entirely realized. Patient number 8 demonstrated a rising thiocyanate level in spite of constant dosage, undoubtedly due to diminished renal clearance of potassium thiocyanate (blood urea nitrogen and the urea clearance were normal in this case). The dosage was reduced to one tablet four times daily with continued good response. A toxic sensitivity reaction in the form of anginal pain was demonstrated in patient 18. This may have been a drug sensitivity as described by Horton and Odel.[8] The anginal pain in this case was in all likelihood due to thiocyanate rather than any temporary drop in blood pressure in view of the fact that the anginal pain was relieved when the thiocyanate was discontinued and a low sodium diet instituted which maintained a lowered blood pressure. Patient number 16 suffered a myocardial infarction while under treatment but we do not feel that this was due in any way to the medication used. Patients 9 and 23 had transient gastro-intestinal disturbances consisting of abdominal distention and mild abdominal cramps which subsided when the drug was stopped for 48 hours and did not return when the drug was resumed at the same dosage. Though there have been many other types of toxic manifestations described and ably summarized by Friedman,[9] we found no others in this series. Four of these patients, as noted in Table 2, received placebo therapy for varying lengths of time with definite rises in blood pressure and increased sub-

8. Horton, B. T., and Odel, H. M.: Proceedings of the Staff Meetings of the Mayo Clinic, 18:279 (August 1943).
9. Friedman, M.: The Medical Bulletin of the Permanente Foundation, 5:49 (July 1947).

jective complaints during this period. When drug therapy was resumed, subjective complaints improved and blood pressure was again lowered. Even though this was a small number of cases, it does show that the therapy had more than a psychotherapeutic value.

At this point, it is well to note the subjective effectiveness of the medication. Ruskin and McKinley[10] find that thiocyanate therapy lowers the blood pressure in many cases but has a distinct tendency to increase the subjective complaints. We did not find it so with this medication. As a matter of fact, in several cases where the blood pressure response was not remarkable, the subjective improvement was most gratifying.

We are unable to state whether this form of therapy would have any effect on retinal hemorrhages or exudates since none of these patients exhibited such phenomena either before or during this therapy. The Gothlin index was normal in all subjects prior to therapy and in no case did the index change during the regime. Certainly we have seen many cases of increased capillary fragility develop in patients in whom maximal thiocyanate levels of 12 to 14 milligrams per cent had been maintained, making us feel that there is some difference in this preparation from thiocyanate alone. We are not prepared to say at this time whether it is the lower thiocyanate level or the Rutin which is the important factor. Further studies without the use of Rutin should be made to answer this question. No significant changes in heart size or the electrocardiograph were noted.

Massie[11] advised against the administration of thiocyanate to patients over 60 years of age because of the danger of increasing toxic effects with increasing age. Like Barker[3] and many others,[12] we found that the older patients often responded especially well and that "they are greatly appreciative of being freed of their symptoms of headaches, heart consciousness, vertigo and visual disturbances". Certainly there are noted considerable variations in thiocyanate blood levels in spite of equal dosage and apparent clinically equivalent renal function in many of our patients. Therefore, we must consider the question of tissue storage which must have a profound effect on the blood level as determined.

10. Ruskin, A., and McKinley, W. F.: The American Heart Journal, 34:691 (November 1947).
11. Massie, E.: International Clinics, 3:198 (1941).
12. Watkinson, G., and Evans, G.: British Medical Journal, 1:595 (May 1947).

SUMMARY

1. A controlled study has been made of the effects of a tablet containing potassium thiocyanate, sodium nitrite, pentobarbital-sodium and Rutin in 24 cases of essential hypertension. The effect of this tablet was compared in the same patients with one or another form of treatment, including a placebo.

2. Hypotensive effects were good or fair in 19 of 24 patients, that is, in 79 per cent: Five of these 24 patients would be considered as having the same good or fair hypotensive effect, using the same criteria, when other modes of medical therapy were employed. Two of these five were on straight potassium thiocyanate therapy in obtaining this comparable result.

3. Placebos were used in four cases and in all of these, within two to eight weeks, it was obvious to both the patients and the investigators that "treatment was failing and something was wrong with the pills". Shortly after the active therapy was resumed, the blood pressure and subjective symptoms returned to pre-placebo levels with satisfaction to all concerned.

4. Only two patients revealed hypotensive effects with other forms of generally accepted therapy. Both of these were on low sodium diets. One of these patients (No. 18) had anginal pain on the therapeutic tablet, while the other (No. 15) had a good hypotensive effect on the therapeutic tablet, but on changing over to the low sodium diet, experienced a further drop in pressure.

5. Subjective complaints were relieved in almost all cases, and the improvement here was well above that which would be expected from the hypotensive effect.

6. Anginal pain as a potassium thiocyanate sensitivity reaction was noted. The infrequency of toxic or sensitivity reactions is emphasized with this preparation. The need

for periodic potassium thiocyanate blood level determinations is again demonstrated.

7. The role of Rutin in this preparation in preventing an increase in capillary fragility is not known. Increased fragility was not present before or after starting therapy. This might indicate some beneficial effect because of failure of any patient to develop this increased fragility.

8. The role of induced hypotension (as produced by this tablet) in the prevention of cerebral hemorrhage, cardiac hypertrophy, failure and retinal changes is not established from present data.

89 Lincoln Park

EARLY DIAGNOSIS OF CANCER OF THE STOMACH*

BENJAMIN COPLEMAN, M.D., Perth Amboy, N. J.

One in three carcinomas in men, and one in five in women, are in the stomach.[1] About one-third of all cancer deaths (or about 35,000 a year) are due to this disease.[2]

About one of three patients with cancer of the breast or cervix may expect a five-year cure, but only one in twenty to fifty of patients with cancer of the stomach will be alive and well after five years. This low cure rate is due to:

1. The nature of the disease is such that onset is often insidious. From 60 to 75 per cent of the cases are non-resectable when first seen.[3] Metastasis may be present with a small primary lesion.

2. The patient may not apply for medical care early enough. He may then refuse to accept the cost of diagnosis and the risk of treatment.

3. The physician may not recognize the indications for a roentgenologic study. A patient with a mass, or anemia, or marked weight loss, or other signs of cachexia "does" not harbor an early cancer. "Indigestion" of more than two or three weeks duration should always be investigated. Too often the patient is treated first, and examined only after the condition has failed to respond to therapy. The medical therapy of an ulcerating gastric lesion should be undertaken only with the realization that about 15 per cent of symptomatically typical "peptic ulcers" of the stomach are really cancer.

4. There is an increasing placement of roentgenologic apparatus in the hands of physicians ill-equipped to use them. There are probably as many deaths attributable to poor radiologic examinations as to poor surgery. Better no examination at all than a poor one.

5. Only an experienced surgeon should attempt the resection. There may be no such thing as an exploratory laparotomy since the lesion may be too small to be found without opening the stomach.

6. The radiologist must assume the task of establishing an early diagnosis. A sound knowledge of the correlation of the roentgenologic and gross pathologic changes is vitally necessary. Routine study of the mucosal relief will teach us to appreciate the small deviations from the normal. The examination of the filled stomach must not be neglected, however. Examination should include mucosal relief studies, exposures with pressure, and polygraphic exposures of the filled stomach. Do not be afraid to repeat the examination; more than once, if necessary.

The most important feature of cancer is the development of rigid areas in the gastric wall. The mass will either protrude into the lumen, or ulcerate, or continue to infiltrate and later contract the lumen.

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* Read before the Section on Radiology of The Medical Society of New Jersey on May 22, 1950.

1. Wilbur, D. L.: Proceedings of the Staff Meetings of the Mayo Clinic, 8:609 (1933).
2. Editorial: New England Journal of Medicine, 242:562 (April 6, 1950).
3. Pack, G. T., and Livingston, E. M.: *Treatment of Cancer and Allied Diseases*. P. B. Hoeber, New York, (1940).

Infiltrating cancer, probably the most common form, produces, first of all, a stiffening of the gastric wall. Normal flexibility to palpation and peristalsis is lost. A small lesion may "ride" the peristaltic wave, and no interruption of peristalsis will be noted. When more of the stomach is involved, an irregular flattening of the wall occurs. Later, a rigid constriction will be found. Because most of the infiltration is submucosal, a normal or almost normal mucosal pattern may sometimes be demonstrated.

In the pyloric region, a stenotic ring is soon produced. The proximal lip of the pyloric fold may be invaded at times, but in almost all instances, the duodenal bulb is spared. The pyloric canal tends to be central in malignant lesions, and eccentric in benign conditions. Infiltration of the pyloric canal may cause it to remain open, so that the stomach acts as a funnel, and emptying may be extremely rapid.

The ulcerating form of cancer is probably due to digestion of a tumor. An attempt should always be made to demonstrate, or exclude, the tumor component in the roentgenologic shadows of an ulcer. Excessive infiltration or nodularity of crater margins are signs to be sought for.

The "meniscus" sign of Carman is produced by the rigid overhanging edge of a carcinomatous ulcer, within the lumen of the stomach. It is elicited most faithfully in the erect position. No reliance should be placed on the finding of radiating folds as indicating a benign lesion. While not a frequent finding, it is found in cancer. Rapid increase in the size of a niche, except on the vertical portion of the lesser curvature, is usually a sign of malignancy. On the vertical portion, a slowly progressing lesion is to be regarded with suspicion.[4] Persistent or progressive irregularity in outline, especially after therapy has been instituted, is also a suspicious sign.

Gutmann[4] lays great stress on the location of the ulcer. Ulcers on the vertical portion of the lesser curvature are almost always benign, while those on the horizontal portion (distal to incisura) are always suspicious. It is likely that there are as many benign ulcers on the greater curvature as malignant. Ulcerations at or near the cardia should always be suspected of malignancy.

The clinical test of an ulcer is its uneventful healing under observation. It should be recalled, however, that Palmer has seen carcinomatous ulcers fill in.

The polypoid cancer is perhaps the most easily diagnosed. It usually reaches a considerable size before producing symptoms or metastasis. It may offer difficulties in diagnosis when small, particularly when near the greater curvature.

The roentgenologic diagnosis of cancer has its limitations, but it is an extremely accurate test, so that a correct differential diagnosis is possible in about 90 per cent of cases, according to Berg. Careful attention to the details of technic and interpretation will mean an increase in five-year cures. Even an increase in a few percentage points will mean (because of the high incidence of the lesion) a large number of lives saved.

280 Hobart Street

DERMATOLOGY-SYPHILOLOGY MEETING

December 2 to 7 are the dates announced for the next annual meeting of the American Academy of Dermatology and Syphilology. Sessions will be held at the Palmer House in Chicago, opening with special courses in histopathology, radiotherapy, mycology, skin anatomy and skin bacteriology. Lectures on a rich variety of dermatologic and syphilologic topics are also scheduled. For detailed program, write to Dr. J. E. Rauschkolb, Box 6565, Cleveland, Ohio.

4. Gutmann, R. A., Bertrand, I., and Peristany, Thomas J.: *Le Cancer de L'Estomac au Debut.* Doin, Paris (1939).

PYLORIC OBSTRUCTION BY A CHOLELITH

REPORT OF A CASE*

Andrew E. Ogden, M.D., Trenton, N. J.

Obstruction of the upper intestinal tract by a gallstone is certainly not rare. The mechanism leading to the obstruction in the patient reported here is both unusual and interesting.

Upon admission to the hospital, the patient gave a history of "gastritis" in March 1948. In September 1949, he had had acute cholecystitis, with right upper quadrant pain, tenderness and vomiting. He had fully recovered in less than three weeks, and experienced no further symptoms until the present illness, seven months later. There had been a seven pound weight loss in eight months.

Twenty-four hours previous to admission, this sixty-four year old, male, rubber-worker started suddenly to vomit dark brown fluid. Upon admission there was no pain, fever, jaundice, tenderness, palpable masses or organs, rigidity or ascites. Blood count and urinalysis were normal, and the serology was negative. X-ray examination showed a greatly dilated stomach filled with barium and food. There was a total obstruction at the pylorus. In such cases it is impossible to differentiate (by x-ray examination) between annular carcinoma at the pylorus and cicatrizing peptic ulcer. The normal blood count, the small weight loss, and the lack of positive physical findings rather pointed away from a diagnosis of carcinoma.

On the hypothesis that there was a peptic ulcer in the pyloric region with concurrent edema causing obstruction, continuous Wangensteen decompression of the stomach was instituted. This was accompanied by adequate parenteral administration of dextrose in saline solution, proteins, vitamins, (K, ascorbic acid, B complex) plasma, and occasional whole blood. At first, the suctioned fluid was dark brown in color, but soon became persistently bile-stained. This finding caused suspicion of pathology additional to the pyloric obstruction. The decompression and gastric lavage were not interrupted to make gastric acidity studies.

Six days later, barium was again introduced for x-ray examination. What was interpreted to be the duodenal bulb was markedly deformed and dilated, and it appeared that there were two penetrating ulcers, one apparently, penetrating from the base of the bulb into the common bile duct, and the other penetrating from the apex into the gall bladder. The supposed duodenal loop was obstructed at this point. Huge quantities of barium entered the biliary tree through the fistulous ulcers and filled out the gall bladder, common duct, cystic and hepatic ducts with their branches.

Immediately following this second barium meal, a mild fever appeared, and the patient complained of a "needling" sensation and of tenderness for the first time in the right upper quadrant. Wangensteen suction was re-instituted and the patient was encouraged to drink large quantities of water to wash the barium from the biliary tree.

Fourteen days following admission, the patient was taken to the operating room with cholecystectomy and partial gastrectomy anticipated, or a gastrojejunostomy, if technical difficulties should present resection. Exploration, however, revealed a gallstone (46 by 36 by 32 millimeters) impacted in the pylorus. The stone was manipulated back into the stomach, and an incision made through the anterior stomach wall. The stone was then removed. Digital examination of the interior of the pylorus disclosed no palpable lesion. About 25 millimeters proximal to the pylorus, however, the exploring finger entered a fistulous opening, and the interior of the fundus of the gall bladder could be palpated. The gallbladder was suspended from the liver by a short peritoneal ligament and was so intimately united with the stomach wall by old adhesions, that it resembled an appendage of the stomach, rather than a separate organ. Curiously, there were no other adhesions in the vicinity. The *tunica serosa* of the liver was streaked with areas of fibrosis, indicating an old in-

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flammatory process. The gastrotomy incision and the abdominal wall were closed routinely, and the Wangensteen suction reinstituted. On the second postoperative day fluids were given orally, and when it was found that there was no gastric retention, the Levin tube was removed.

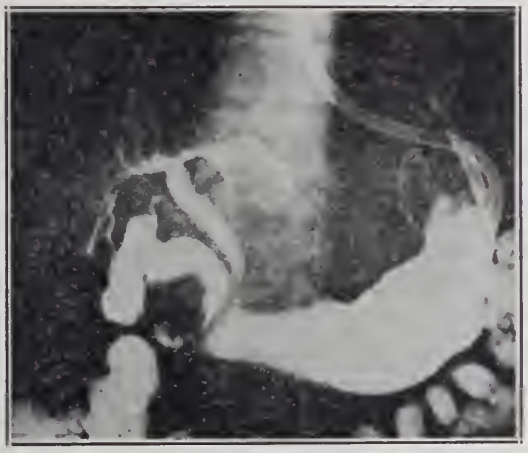

Figure 1.

1. Pyloric obstruction by a gallstone. Illustrating a cholecystogastric fistula with barium filling the gall bladder, common duct, cystic and hepatic ducts with their branches.

Figure 2.

2. The removed gallstone, which proved to be practically pure cholesterol.

Four weeks following operation, the esophagus, stomach, and duodenal cap were demonstrated (by x-ray examination) to be completely within normal limits, with the exception of the above-mentioned fistula. The cystic duct, gall bladder, and common bile duct, were again outlined spontaneously with barium. The stomach emptied normally. Only trace amounts of barium entered the hepatic ducts, indicating that there was much less retrograde pressure and flow from the fistula toward the liver. Oral cholecystography showed no concentration of the contract medium in the gall bladder fundus, probably because the gall bladder was shrunken and the contents were expelled so rapidly through the cholecystogastric fistula.

Recovery was uneventful. When last observed, five months after operation, the patient had returned to work, and there were no digestive disturbances. The cholelith proved to be practically pure cholesterol.

COMMENT

The mechanism leading to the obstruction was the perforation by a gallstone through the adherent walls of the gall bladder and stomach.

Babcock[1] in 1920, advised cholecystogastrostomy in the treatment of gastric and duodenal ulcers, for the purpose of neutralizing gastric hyperacidity with the alkaline contents of the gall bladder. The contention that bile contents in the stomach are harmful was rejected as fallacious by Oddi,[2] (probably the first to perform experimental cholecystogastrostomy to ascertain the effect of bile on gastric acidity) Dastre,[3] and Beaver.[4] Beaver,[4] however, found that in dogs the bile definitely does not have any effect on the acidity of the stomach, but infections of the biliary tract and liver, (varying from only slight round cell infiltration to definite localized and miliary abscesses throughout the liver) always occur following cholecystogastrostomy. Little is found in the literature, recording similar results in the human patient. Wangensteen[5] did report cholangeitis following cholecystoduodenostomy, performed for obstructive jaundice due to malignancy of the head of the pancreas. That such a probability exists, however, is indicated by the postoperative x-ray findings in the patient here recorded.

In view of the age and general physical condition of the patient, and the favorable clinical results reported in cholecystogastrostomy, further radical surgery was not considered.

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1. Babcock, W. W.: Transactions of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, 33:323 (1920).
2. Oddi, Ruggero: *Archives Italiennes de Biologie.* (Pisa) 9:138 (1888).
3. Dastre, A.: *Archives de Physiologie normale et pathologique,* 2:315 (1890).
4. Beaver, Meredith G.: Archives of Surgery, 18:899 (1929).
5. Wangensteen, O. H.: Annals of Surgery, 87:54 (1928).

SUMMARY AND CONCLUSIONS

1. A case of pyloric obstruction by a cholelith has been reported.

2. The mechanism leading to the obstruction was the development of a fistula between the gall bladder and the stomach, by the passage of a gallstone by perforation.

3. It is definitely demonstrated by roentgenograms that a substantial amount of stomach contents does enter the biliary system through a cholecystogastric fistula.

1829 Greenwood Avenue

ANESTHESIA FOR GYNECOLOGIC AND OBSTETRICAL OPERATIONS *

Edward B. Tuohy, M.D., Washington, D. C.

In obstetrics we have a dual responsibility: mother and unborn child. Conservatism is most important when there is this dual consideration. This discussion will not deal with normal uncomplicated obstetrics with respect to premedication and anesthesia, but to conditions which necessitate operative delivery and the management of some of the more frequent gynecologic operations. Injudicious management of premedication, however, may provoke or initiate operative obstetrics. Too much sedation and prolonged labor may seriously jeopardize the fetus.

The following situations, at least in part, comprise operative obstetrics: caesarean section, podalic version, retained placenta, mid and high forceps delivery, persistent uterine hemorrhage, placenta previa in certain cases, premature separation of placenta, uterine rupture, pregnancy with single or multiple large fibroids, cervical dystocia, transverse lie, et cetera.

Anesthesia for caesarean section can be divided into the following categories: (1) local anesthesia; (2) local anesthesia plus inhalation or intravenous anesthesia; (3) spinal and epidural (caudal); (4) inhalation or intravenous anesthesia alone or in combination with each other.

More recently, we have been using spinal and epidural anesthesia rather than inhalation and intravenous anesthesia. The reason is that there is less fetal respiratory depression and a greater newborn salvage because we have less asphyxia in the newborn infants. Formerly, before blood transfusions were so readily available, it was a firm belief of many that spinal or epidural anesthesia was contra-indicated in caesarean sections and similar operations. This attitude has been modified in recent years. Because of the ready access of adequate blood replacement, I feel that spinal anesthesia or epidural is quite safe.

A cardinal point in supportive intravenous fluid replacement is the use of large intravenous needles, No. 15 gauge preferably. These large bore needles will permit the rapid administration of blood and fluid even under pressure, if needed.

If local anesthesia is used along with intravenous anesthesia, it is important to withhold the intravenous agent until just a few moments prior to opening the uterus. Prolonged administration of intravenous anesthesia may cause serious fetal respiratory depression. Likewise, prolonged inhalation anesthesia may cause the same end result. Except in unusual circumstances, local anesthesia is not adequate for pain relief in caesarean section. All premedication should be carefully evaluated as to dose and time of administration. Avoid respiratory depressing drugs within one hour of the contemplated time of surgery.

Certain steps in operative and anesthetic technic seem to enhance the morbidity and mortality figures in caesarean section. They are not original by any means, but I believe they are worthy of mention. We are aware of the existing mortality figures countrywide, and

* Read by invitation before the 184th Annual Meeting of The Medical Society of New Jersey in Atlantic City, on May 22, 1950.

it appears that pulmonary complications and shock with anoxemia are two serious factors. The suggestion has been made that the stomach of all newborn section babies be aspirated gently immediately upon delivery because there is a fairly large amount of detritus and amniotic fluid present therein, which may be readily vomited and aspirated. We have been following this suggestion recently and have been amazed at the fluid that can be aspirated from the stomach. It amounts to one to one and one-half ounces as a rule. A small catheter can be passed into the esophagus and stomach with minimal trauma and difficulty for the purpose of aspirating the fluid.

A second suggestion by Landau† is that the placenta be removed simultaneously with the newborn infant; wrapping the placenta in a towel, and with the umbilical cord still intact, gravity is used to augment the total blood volume of the baby. As much as 95 to 100 cubic centimeters of blood can be added to the infant. This is a substantial addition to the newborn and affords protection against shock and anoxemia.

Podalic version requires profound muscular relaxation and because of the circumstances it is usually impossible to resort to anything but inhalation anesthesia. Ether is probably one of the safest agents to use in cases with adequate oxygen. Muscle relaxants (such as curare and syncurine) have provided another method for producing profound relaxation for version extractions. They can be added practically instantaneously to augment an inhalation anesthetic. They obviate the necessity for deep narcosis by such agents as ether or cyclopropane. Allegedly, curare is not transmitted across the placenta to the fetus, so this hazard is apparently not real. The muscle relaxants have their action on skeletal muscle only.

MANAGEMENT OF THE NEWBORN IN OPERATIVE OBSTETRICS

Every precaution related to the cause of asphyxia neonatorum should be taken. Gentle care and adequate pulmonary ventilation with oxygen are most important. Babies who are slow or reluctant to respond to the usual measures of artificial pulmonary ventilation should be watched most carefully. Bronchoscopy may be indicated, or special methods may be needed for inflating a partly or totally collapsed lung. Not infrequently one encounters fetal atelectasis with congenital maldevelopment which precludes any successful attempts to bring about normal lung expansion.

GYNECOLOGIC ANESTHESIA

Perineal and vaginal operations are not as foreboding from the anesthesia standpoint as are those requiring laparotomy. In the former instance local block or infiltration is adequate, particularly in elderly persons, and intravenous anesthesia will be adequate for many operations. Caudal anesthesia (with or without intravenous supplement) also is useful. Caudal analgesia does not provide anesthesia of the lower extremities, and considerable attention should be given to the support of the legs, and particularly the popliteal space when using the leg supports.

A common complication of intravenous anesthesia, or in fact general inhalation anesthesia in vaginal hysterectomies or similar operations, is laryngeal stridor. Traction on the uterus and adnexae is the most probable cause. Not all cases of spasm can be avoided, but a reasonable number can be prevented by establishing the proper depth of anesthesia *before* commencing any surgery. A simple test of anesthesia depth can be made by pinching the skin on the inside of the arm or over the chest. This stimulus will usually produce obvious motion or even laryngeal stridor in light planes of anesthesia. One should not, therefore, start surgery until the patient will tolerate a stimulus of the nature mentioned. Another error in intravenous anesthesia technic is the inattention paid to support of the lower jaw when anesthesia is induced, and also the use of pillows under the patient's head while inducing anesthesia. If the jaw is not supported and the head allowed to reman in moderate flexion, hiccough frequently may develop.

The Trendelenburg position is important in spinal anesthesia. Do not tilt the head of the table sharply until the level of anesthesia is carefully established. Allow ten to fifteen min-

† Landau, D. B.: Journal of Pediatrics, 36:421 (April 1950).

utes to elapse after administering the spinal anesthetic before placing the patient in a head-down position.

Breaking of the table, which allows the legs to bend at the knees is not to be condemned, but should be done accurately. If too much flexion is made, the mechanical pull on the abdominal muscles may mitigate against otherwise good muscle relaxation.

Disturbances in circulation will occur under spinal and general anesthesia when intra-abdominal pressure dynamics are disturbed. A large fibroid, or ovarian cyst, normal caesarean section, ascites, et cetera, will influence blood pressure materially. Blood pressure may drop to "zero" when a large tumor is removed. Prompt support of blood pressure is needed by means of blood, fluids, vasopressors and oxygen.

Labored, jerky respirations are very troublesome and prevent the production of a "quiet abdomen". Intratracheal technic of general anesthesia with or without controlled respiration will correct this difficulty. Ninety per cent of difficulties associated with general anesthesia revolve about a patent airway. Labored, partly obstructed respiration cannot be tolerated. Physical fatigue and hypoxemia are too dangerous to the patient.

"TOO MUCH CURARE"

A word of caution is necessary with curare or any similar muscle relaxant. The dose of curare like that of morphine is enough, but not too much. Curare will produce relaxation, but it can also cause respiratory arrest. We must be prepared to provide artificial pulmonary ventilation when apnea occurs. This means equipment and ability to perform intratracheal intubation.

Neostigmine, and a new prostigmine analogue are the pharmacologic antidotes to curare over-dosage. The latter drug is most interesting and appears to have singular merit. However, we should not rely upon curare antidotes for safety. I dwell upon safe technic with curare or similar agents, because there appears to be a trend of technic and thinking that upholds intravenous anesthesia with curare to the exclusion of all other agents and methods of anesthesia. This is not fundamentally sound as a routine procedure.

Another common error in this type of surgery, as well as general abdominal surgery, is the augmentation of a poor half-hearted spinal anesthetic with intravenous anesthesia. This can lead to more trouble and confusion than any one of you has tolerance to endure.

SUMMARY

(1) Do not delay in action when dealing with operative obstetrics. Be sparing of respiratory depressants, plan the anesthesia and fluid therapy, see to it that they are adequate for the procedure.

(2) Prompt attention to the handling of the newborn with adequate resuscitation equipment.

(3) A poor spinal anesthetic is rarely rejuvenated by intravenous anesthesia.

(4) Curare is a muscle relaxant not an anesthetic. Be careful in its administration.

(5) The best anesthetic agent yet known for general narcosis will not correct a bad airway. Provide a patent airway, remove from the patient's chest the weary arms of unthinking assistants, and remember that it is hard work to breathe "up hill" in the Trendelenburg position for hours on end.

(6) A well administered ether anesthetic is still a good procedure when relaxation and safety are needed.

(7) Special type of regional anesthesia, including spinal and epidural have their place, but cannot be considered applicable in all cases.

(8) Try to have just and adequate reason for using certain technics. We should be able to defend our action and show that we exercised care and diligence in the management of the case.

(9) Overdose with most agents can be avoided. We administer general anesthesia in fractional amounts, and it is now possible to handle spinal and epidural anesthesia in a similar manner. Intermittent administration is the keynote of safe anesthesia. Careful surgery and proper anesthesia management will foster better medical and surgical care.

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HEMORRHAGIC DISORDERS*

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It is customary to separate hemorrhagic disorders into abnormalities of (1) the smallest blood vessels, (2) the blood platelets, and (3) the mechanism of blood coagulation. The central element in hemostasis (as in thrombosis) is the blood platelet; its substrate is the minute blood vessel; its activator is thrombin. Fibrin is an accessory factor which adds reinforcement and bulk to the hemostatic peg formed primarily from platelets.

The platelets are believed to undergo slow lysis in circulation normally, giving up to the serum a specific smooth muscle contracting substance (serotonin) which maintains normal tonus in the smallest vessels: deficiency in platelet vasoconstrictor due either to numerical lack of platelets, to faulty platelet protoplasmic structure or to inhibited platelet lysis, results in fragile, toneless, dilated small vessels, unresponsive to mechanical stimulation and stretched under slight stress to produce petechiae and ecchymoses. Platelet lysis is believed to begin with swelling and increased stickiness of its outer protoplasm. Stickiness and lysis are greatly accelerated by thrombin formed in course of coagulation; the products of platelet lysis include enzymic factors which accelerate conversion (1) of plasma thromboplastin precursor into active thromboplastin and (2) of prothrombin until all the locally available platelets and clotting factors are completely activated. As a result vascular defects in normal subjects quickly close under the combined influence of agglutinated platelets, platelet vasoconstrictor substance, and accelerated clot formation.

Two hormone-like substances, thrombocytosin and thrombocytopen, seem to potentiate these effects in opposite ways, thrombocytosin (present in adipose tissue) increasing the rate of breakup of megakaryocytes into platelets and favoring platelet adhesiveness and lysis, and thrombocytopen (present in the spleen) repressing these effects.

Thrombocytopenia may result from thrombocytopen excess (hypersplenism), which may be "primary" (idiopathic), i.e. without known cause, or secondary to non-suppurative systemic infections or other causes of reticuloendothelial hyperplasia accompanied by splenomegaly, or secondary to certain endocrine changes (hyperthyroidism, pregnancy).

Thrombocytopenic purpura resulting from numerical deficiency of megakaryocytes (marrow aplasias, leukemic and other marrow infiltrations) may be differentiated from hypersplenic purpura by presence of normal or increased platelet adhesiveness in the presence of marked thrombopenia; in hypersplenism adhesiveness is extremely low and purpura occurs even when total count is only moderately reduced.

Thrombocytopenic purpura may be produced by excessive removal of platelets from circulation as a result of clumping, e.g. experimentally (antiplatelet serum, anaphylactic shock, intravenous injections of various colloids or peptone), administration of allergenic drugs (quinine, sedormid[1]), or as an acute febrile illness with anemia and marked leucocytosis (Moschcowitz's Disease). Purpura fulminans may result from rapid clumping of platelets about bacteria in circulation (meningococcus sepsis). Purpura may also follow rapid withdrawal of platelets as a complication of widespread vascular disease with thrombosis (disseminated lupus erythematosus) or in the formation of multiple bland thromboses (essential thrombophilia or the thrombophilia of cancer).

In addition to *non-thrombopenic purpura* caused by inborn errors of platelet formation (congenital hemorrhagic thrombocytic dystrophy, Bernard and Soulier), platelet dysplasia may develop as part of the pre-neoplastic disorder referred to as "erythroleukemia" either as a subgroup (idiopathic thrombocythemia, hemorrhagic thrombocythemia) or associated with polycythemia vera.

Inborn errors of the small blood vessels may give rise to purpura in the presence of normal platelets, presumably because of faulty reactivity to vasoconstrictor substance (familial

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1. Sedormid is the Hoffmann-La Roche registered trade-name for a brand of allyl propyl accryl carbamide.

purpura simplex; heredofamilial telangiectasia). Pseudohemophilia, congenital or acquired, probably falls into this group. A variety of metabolic abnormalities, toxicoses, inflammatory and trophic disorders may similarly predispose blood vessels to dilate and rupture.

Coagulation disorders in which thrombin formation is delayed (hemophilia) or normal (congenital afibrinogenemia) display abnormal bleeding only when larger vessels are torn. Inasmuch as physiologic platelet lysis within the circulating blood is unimpaired, vasoconstrictor tone in the smallest vessels is normal, capillary fragility and bleeding time are normal, and petechiae and small ecchymoses are not seen. Similar normal findings occur in the small vessels in hypoprothrombinemia or when prothrombin conversion is retarded (certain cases of congenital hypoprothrombinemia, Owren's disease, moderate heparin overdosage). However, when platelet lysis is suppressed, e.g. by marked overdosage with heparin or Dicumarol,[2] vascular function is seriously affected so that vasodilatation, spontaneous petechiae and prolonged bleeding time result. This has also been produced experimentally in mice with heparin (Copley) and in dogs with Dicumarol[2] (Bingham). The hyperheparinemia with hemorrhagic tendency produced by universal body roentgen irradiation or nitrogen mustard or produced by intravenous histamine (e.g. for migraine) in predisposed human subjects may be the result of mobilization of endogenous heparin into the circulation from perivascular heparinocytes. A similar mechanism may underlie the local hemorrhagic manifestations of urticarial purpura (Henoch-Schoenlein), or the diffuse nonthrombopenic purpuras which may at times accompany acute anaphylaxis.

SUMMARY

Hemostasis is normally subserved by blood platelets which, by their physiologic lysis, liberate serotonin and thereby maintain the normal tonus and reactivity of the small blood vessels. In the presence of vascular injury platelets adhere in great number to the edges of the defect as a "hemostatic peg" and also liberate large concentrations of serotonin and of clot accelerating factors. Fibrin is an important accessory but not an absolute pre-requisite for hemostasis. Hemorrhagic disorders may arise on the basis of acquired or inborn failure of repression of any one of the elements of normal hemostasis, viz. blood vessel responsiveness to serotonin, blood platelet number and physiologic adequacy, and coagulation mechanisms. Platelet lysis is greatly accelerated by thrombin, which also mediates platelet adhesiveness, even in the absence of fibrin. The responsiveness of platelets to thrombin as well as the rate of segmentation of the cytoplasm of megakaryocytes into platelets are enhanced by a hormone-like substance, thrombocytosin, liberated from adipose tissue by various agencies, and suppressed by its antagonist, thrombocytopen, which is formed by the spleen. When produced in excess the latter may produce purpura. Other causes of purpura are briefly enumerated, also the role of specific elements of the coagulation mechanism in hemorrhagic disorders.

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2. Dicumarol is the collective trade name for methylene hydroxy coumarin registered by the Wisconsin Research Foundation.

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GAS BACILLUS INFECTION OF ABDOMEN FOLLOWING APPENDECTOMY

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Gas bacillus infection of the abdomen following appendectomy is rare. In a review of the literature* from 1925 to 1944, we found recorded only 24 cases of clostridium perfringens infection of the abdomen following appendectomy with nine recoveries and fifteen deaths, a mortality rate of 62.5 per cent.

It is not known why gas bacillus infection of the abdomen does not complicate abdominal operations more often. By far the greater number of cases of gas bacillus infection of abdomen have followed appendectomy; although it has also complicated enterostomies, gallbladder surgery, gastric operations and herniopiasties in that order of frequency.

Clostridium welchii is normally present in the gastro-intestinal tract. Jennings[1] reports that in 90 per cent of appendices removed at operation, bacillus welchii was found by cultures made from the contents of the appendiceal lumen. He also recovered the bacillus from the muscular wall of an inflamed appendix as well as from the lumen content. In 40 cases in which cultures were taken from free fluid in the pelvis or general peritoneal cavity, this organism was found 10 times: an incidence of 25 per cent. The mere presence of bacillus welchii does not mean clinical infection.

DIAGNOSIS

Early recognition is important and may, indeed, be a matter of life or death. When present, gas bacillus infection is usually first evident within 36 to 72 hours after operation, and its presence is signalled by an abrupt rise in pulse and temperature combined with evidences of prostration, restlessness and severe pain in the operative wound area. Locally, the wound appears edematous, very tender and shows some swelling. The skin of the wound becomes dusky in color and a serosanguineous fluid may exude. Palpation of the wound yields the tell-tale crepitus sensation. Smears and anerobic culture will be positive for bacillus welchii.

TREATMENT

Treatment includes gas-bacillus antitoxin, sulfa drugs, x-ray therapy (either among themselves or combined with surgical treatments), multiple incisions, debridement, zinc peroxide dressings or hydrogen peroxide irrigations.

In our case, a combination of massive doses of penicillin, streptomycin, blood transfusions, gas-gangrene antitoxin, sodium sulfa-diazine, and x-ray therapy had no influence on the final outcome.

CASE REPORT

A 39-year old male was admitted to the "A" Surgical Service of the Newark (N. J.) City Hospital complaining of abdominal pain. The present attack had begun 24 hours prior to admission. The pain was experienced in the right lower quadrant and there was also some peri-umbilical pain. He had nausea but no vomiting and no irregularity of bowel movement. He had had several previous and similar attacks during the few months prior to admission.

On admission, rectal temperature was 101 but pulse was only 72. Blood pressure was 120/70. The only positive physical finding was tenderness in the right upper and right lower quadrants with some rebound at McBurney's point. There was also slight rectal tenderness on the right. Leucocyte count was 7250, and of these 88 per cent were polymorphonuclear cells and 12 per cent were lymphocytes. Hemoglobin was 81 per cent and red cell count tallied 4,500,000. Urine was negative.

A diagnosis of acute appendicitis was made, and the operation was scheduled for 1½ hours after admission. It was done under nitrous oxide-oxygen-ether anesthesia.

Through a right rectus muscle-splitting incision, a retrocecal mildly injected appendix was revealed with a partly rotated cecum so that the appendix lay near liver. After considerable difficulty, it was removed with a merthiolate knife and the stump was buried with purse-string. There was no free fluid in the abdomen. A congenital adhesion (Lane's kink) was found constricting the ileum about 4 inches from the ileo-cecal valve. This was freed and the abdomen was closed without drainage.

For the first eighteen hours after operation, the patient's condition was good. Suddenly the temperature soared to 104 and the pulse rose to 100. The patient complained of abdominal pain. He looked toxic. The wound was edematous and some-

* See table on page 520.

what blue in color. Definite crepitation was felt extending from the wound to the suprapubic area and towards the right flank.

Gas bacillus infection was, of course, suspected. Immediate treatment consisted of a million units of penicillin, followed by another million units every three hours. This was given intramuscularly. We also administered 500 milligrams of streptomycin every six hours. A Miller-Abbott tube attached to a Wangensteen suction was installed. We ordered transfusions of 250 cubic centimeters of blood daily.

The patient was tested for sensitivity to the antitoxin and then we gave gas gangrene antitoxin, nine therapeutic doses every seven hours in a liter of normal saline. We took three hours to administer the antitoxin and then allowed a four hour rest period before resuming. We also applied x-ray to the abdomen, and administered sodium sulfadiazine intravenously, five Grams every 12 hours.

A smear from the wound exudate and anerobic cultures (twice repeated) were consistently positive for the clostridium welchii.

Temperature dropped from 104 to 100 on the fourth postoperative day. Pulse remained constantly between 110 and 120. On the fifth day, temperature rose again to 104 and remained there until the patient's death on the seventh postoperative day. Pathologic report showed chronic appendicitis. Autopsy permission was not obtained.

In all, we had administered 48 million units of penicillin, 11 Grams of streptomycin and 180 therapeutic doses of the gas bacillus antitoxin.

A summary of previously reported cases of gas bacillus infection following appendectomy is displayed in the table below. Our own case is included.

Oddly enough, the death rate in cases reported in and after 1936 is 9 out of eleven or 81 per cent; in the group prior to 1936, the death rate was six out of thirteen, a ratio of only 43 per cent.

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Author [3]	*Year*	*Cases*	*Diagnosis*	*Operation*	*Treatment*	*Result*
Ochsner [5]	1925	1	AAb	A & D	Dakins Irrig. Hydr. Peroxide	Rec.
Butler [6]	1926	1	AAb	A & D	Incis. & Drain	Rec.
Lamprecht [7]	1928	1	AAb	Drainage	Antitoxin	Died
Shearer [8]	1929	1	Gang	A	?	Died
Eckhoff [9]	1930	2	Ch. A.	A	ID & Dakins	Rec.
			Ac. A.	A	ID & Flavines	Rec.
Douglas [10]	1931	1	A Ab	Drainage	Antitoxin	Rec.
King [11]	1931	1	A Ab	A	Antitoxin	Rec.
Miyamoto [12]	1932	1	Ch. A.	A	Antitoxin	Rec.
Traver [13]	1933	1	A Ab	Drainage	I & D	Died
Orr [14]	1934	1	A Ab In. O.	Enterostomy	I & D	Died
Gamble [15]	1935	3	Gang	A & D	I & D	Rec.
			A Ab	D	I & D	Died
			Ac. A.	A & D	I, D, Antitoxin	Rec.
Howe [16]	1936	1	Ch. A.	A	Antitoxin	Rec.
Johnson [17]	1936	2	A Ab	D	Antitoxin	Rec.
			Gang.	A & D	Antitoxin	Died
Lober [18]	1938	1	Ac. A.	A	Hydr. Peroxide I & D	Died
Coleman [19]	1939	3	?	?	?	Died (3)
Smith [20]	1939	1	Perf	A	Antitoxin	Died
Perard [21]	1939	1	A Ab	D	Antitoxin	Died
Breslin [22]	1940	1	Subac	A & D	Antitoxin	Died
Cappiello [23]	1950	1	Ch. A.	A	See text	Died

Abbreviations used in this table: A—appendectomy; *A Ab*—appendiceal abscess; *Ac A*—Acute appendicitis; *Ch A*—chronic appendicitis; *D*—drainage; *Gang*—gangrenous appendix; *I*—incision; *In O*—Intestinal obstruction; *Perf*—perforated appendix; *Rec*—recovered; *Subac*—subacute appendicitis, and *?*—information not furnished.

Bibliography will appear in authors' reprints.

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MALIGNANCY IN GASTRIC ULCER*

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Primary carcinoma of the duodenum is extremely rare as shown by the paucity of case reports. It has never been demonstrated conclusively that any duodenal ulcer has ever undergone malignant degeneration. Thus the question of malignancy in duodenal ulcer rarely, if ever, arises. When peptic ulcer occurs in the stomach, however, the situation is quite different inasmuch as 10 to 20 per cent of gastric carcinomas appear as simple ulcerations. It is the purpose of this paper to discuss the differential diagnosis of benign and malignant gastric ulcer.

Roentgenograms of the stomach showing an irregular filling defect, an obviously ulcerating neoplasm or the diffusely infiltrating lesion of scirrhous carcinoma offer no difficulty in diagnosis. It is the gastric neoplasm masquerading as a benign ulcer and appearing on the roentgen film as a niche or crater that presents a perplexing problem to the roentgenologist and clinician.

The question of whether benign gastric ulcers may undergo malignant degeneration or whether all malignant gastric ulcers are carcinomatous from the start is a controversial subject. Bockus[1] feels that carcinoma of the stomach and benign gastric ulcers are separate and distinct diseases and that cancer of the stomach probably occurs no more frequently in patients with gastric ulcer than should be anticipated on the basis of chance.

In the present state of our knowledge we are often unable, after careful and thorough initial study of the patient with a gastric ulcer, to distinguish with certainty the malignant from the benign lesion. Smith and Jordan,[2] in analyzing a group of 600 gastric ulcers at the Lahey Clinic, noted that 59 or 9 per cent were malignant. Of this group of proved malignant lesions 52 per cent were thought to be benign after initial study. Of 211 proved benign ulcers 42 per cent were brought to surgery because of an erroneous diagnosis of cancer or probable cancer. Allen and Welch,[3] in reviewing their experience over a ten year period at the Massachusetts General Hospital, reported that of 277 patients with an original diagnosis of gastric ulcer 39, or 14 per cent, proved to have cancer. In this same study, of 69 cases subjected to gastric resection with a pre-operative diagnosis of benign ulcer, 30, or 43 per cent had a final diagnosis of cancer.

One solution of the problem would be to operate on all patients with gastric ulcer as advocated by Lahey and many others who feel that this lesion is primarily a surgical disease. Trend in recent years has been toward more frequent and more radical resections for gastric ulcer. However, immediately to recommend surgery for every gastric ulcer patient would unfairly subject a certain number to the low but definite mortality and morbidity accompanying gastric resection. Another answer would be to treat all patients medically and ignore the possibility of malignancy. This deprives the patient with a neoplasm of his only chance for cure. It is felt that each case should be considered individually and a decision made after carefully weighing the clinical picture, roentgen findings, laboratory data and gastroscopic findings. Unless the initial work-up points strongly to or is suggestive of a malignant lesion, a short therapeutic trial on ulcer therapy should be carried out. If there is the slightest doubt, surgery should not be delayed.

The clinical picture may or may not help in distinguishing benign from malignant ulcer. The age of the patient is of little value in the individual case since cancer may be present in the young and benign ulcer in the old. However, carcinoma of the stomach is unusual under the age of 30. About 75 per cent of the cases occur in patients beyond the age of 50. Both benign and malignant ulcers are more common in males than in females. The char-

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1. Bockus, H. L.: *Gastroenterology*, Vol. I, Philadelphia, W. B. Saunders Company, p. 419 (1944).

2. Smith, F. H., and Jordan, S. M.: Gastroenterology 11:575 (Nov. 1948).

3. Allen, A. W., and Welch, C. E.: Annals of Surgery, 114:498 (Oct. 1941).

acter of the symptoms may be identical in benign and malignant ulcer. The patient with a malignant ulcer may present the classical ulcer type of pain at variable intervals after meals with relief by food. The symptoms may temporarily disappear on the usual medical treatment given to patients with benign ulcer. Night pain is as frequent in patients with malignant ulcer as in those with the benign form. Weight loss is almost as frequent but not as progressive in benign as in malignant ulcer.

Massive hemorrhage is by far more common in the benign than in the malignant lesions but may occur in the latter. Duration of the symptoms is an important aspect of the clinical picture. If symptoms have occurred with characteristic remissions and relapses and the episode under consideration does not differ from previous attacks the lesion is probably benign. However, ulcerating carcinoma may occur in patients giving a long history of epigastric distress. Allen[4] noted that in patients over the age of 45 with symptoms for less than one year, 80 per cent had malignant lesions, while those with symptoms for five or more years the reverse was true, that is, 80 per cent were benign. In general a long history speaks for benign ulcer while if symptoms have existed for only a few months, malignancy must be more seriously considered.

The physical examination is of little help prior to the stage in which a diagnosis of malignant disease is easily made by roentgen study. A careful physical examination should be done, however, with particular attention to the presence or absence of an epigastric mass, liver enlargement, Virchow's node or a rectal shelf.

The laboratory offers only limited assistance in diagnosis. A gastric analysis, showing absence of free hydrochloric acid, particularly after histamine stimulation, is of help but one showing the presence of hydrochloric acid is of no aid in the differential diagnosis. Any grade of hyperchlorhydria may be present in malignant ulcer. Finding a normal or high acidity does not rule out this diagnosis. Most gastric cancers (characterized morphologically by ulceration) occur in stomachs which secrete hydrochloric acid. In Smith and Jordan's series,[2] 21 per cent of the proved malignant ulcers had a free acidity titer of 51 units or higher. Consistently positive reactions for occult blood in the stools two weeks or more after the institution of strict therapy bolster the suspicion of malignancy. The Papanicolaou technic for the cytologic study of aspirated gastric contents has not as yet proved very helpful in the diagnosis of gastric carcinoma. By methods thus far devised, samples obtained by aspiration are often unsatisfactory for study. Even in the hands of those well trained in the technic, the proportion of positive reports is low. In known cases of carcinoma of the stomach, false negative or indefinite reports may run as high as 65 per cent.[5] Swarts *et al.*[6] obtained unsatisfactory preparations in 49 per cent of 67 cases of gastric carcinoma. In the remaining 34 cases a correct positive diagnosis was made in 44 per cent and an incorrect diagnosis in 56 per cent. It is hoped that further experience and improved technic will increase the usefulness of this method of examination.

The roentgen examination is the most important single method of diagnosis. The size of the crater as seen on the roentgen film is no criterion for differential diagnosis in itself although many observers believe that those over 2.5 centimeters wide should be considered malignant. Some malignant ulcers are very small while many benign ulcers are large. In general, however, the smaller the crater the more likely it is to be benign. Very large craters, particularly of the shallow type, are more likely malignant. The penetration or depth of the niche is of some significance. When it projects well beyond the luminal margin of the lesser curvature the lesion is probably benign. The location of the ulcer has some significance. Any niche on the greater curvature should be considered malignant since benign ulcers are extremely rare in this location. Lesions in the pre-pyloric region are often malignant. Lesions on the lesser curvature proximal to the incisura angularis are usually be-

4. Allen, A. W.: Review of Gastroenterology, 16:13 (January 1949).
5. Pollard, H. M., Bryant, H. C., Block, M. and Hall, W. C.: Journal of The American Medical Association, 139:71 (Jan. 8, 1949).
6. Swarts, J. M., Ragins, A. B., Bernstein, A., and Meyer, J.: Gastroenterology, 14:265 (Feb. 1950).

nign. Allen[4] noted that nearly all ulcers on the greater curvature were malignant and that the incidence of malignancy was 65 per cent in the pre-pyloric region, 10 per cent on the lesser curvature and at the pylorus, and 20 per cent on the anterior and posterior walls. On the other hand, Carty,[7] analyzing data from the Mayor Clinic over a five year period, concluded that pre-pyloric ulcers are no more likely to be carcinomatous than ulcers situated elsewhere in the stomach. It should be remembered that although there are so-called "safer" zones, an ulcer located anywhere in the stomach may be malignant in the individual case.

The presence of a filling defect in association with a niche is pathognomonic of malignancy. The meniscus sign of Carman (a translucent halo surrounding a niche) also points to malignancy. A study of the mucosal pattern may be of some assistance. In benign ulcer, the radiating mucosal folds converge toward the ulcer crater while in carcinoma the folds tend to be effaced in the region of the crater or terminate abruptly some distance from the margin of the lesion. The contour of the crater is of no great value in differentiation although benign ulcer characteristically has a smooth outline whereas malignant ulcer is often irregular. The presence of a deep smooth spastic incisura on the greater curvature opposite a niche on the lesser curvature is indicative of a benign lesion in the great majority of cases. Incisura-like defects are sometimes seen opposite malignant ulcers but they are usually shallow, often broad and usually quite irregular.

The association of a definite duodenal ulcer favors a diagnosis of a benign gastric lesion since gastric malignancy, though possible, is rare in the presence of a duodenal ulcer. It must be stressed, however, that simple deformity of the duodenal bulb may be due to causes other than ulcer. Fischer *et al.*[8] in a study of 45,000 cases of duodenal ulcer at the Mayo Clinic found only one co-existing carcinoma of the stomach in every 938 cases of duodenal ulcer—an incidence of only one tenth of one per cent.

The importance of the *fluoroscopic examination* in conjunction with roentgenographic examination cannot be too strongly stressed since the fluoroscopist has the advantage of being able to study the stomach in motion and of noting the presence or absence of rigidity of the gastric wall and whether or not peristaltic waves pass through a suspected area.

Gastroscopy may be of real value in the differential diagnosis of benign and malignant ulcer but it is far from infallible. The flexible gastroscope does not show every portion of the stomach. There are certain blind areas which vary in size in different subjects. The typical benign lesion and the typical malignant lesion adequately described in text books are easily recognized by the gastroscopist. Often, however, he is unable to distinguish with certainty between the two, even as is the surgeon or the pathologist with the gross specimen in his hand. A positive report from the gastroscopist carries more weight than a negative one. Roentgen study and gastroscopy are complementary and both methods should be employed. In 124 cases of the Smith and Jordan[2] series where gastroscopy was done, examination was unsatisfactory in 25 per cent. Where a satisfactory examination was possible, the diagnosis was accurate in 73 per cent and inaccurate in 27 per cent. Engel[9] noted that when a lesion was known to be present the error in differentiating ulcer and carcinoma was 34 per cent by roentgen study, 20 per cent by gastroscopy and 14 per cent when both methods were used. The recent appearance of the gastroscope fitted with a device for taking biopsy material under direct vision[10] offers an additional aid for more accurate diagnosis in these gastric lesions.

MANAGEMENT

After careful initial study of each patient a decision must be made as to therapy. All cases of ulcer on the greater curvature, all with histamine achlorhydria and all patients showing a menicus sign or associated filling defect should have immediate surgery. Many author-

7. Carty, W. C., Jr.: Journal of The American Medical Association, 120:733 (Nov. 1942).
8. Fischer, A., Clagett, O. T., and McDonald, J. R.: Surgery, 21:168 (1947).
9. Engel, G. C.: Journal of The American Medical Association, 135:687 (October 1947).
10. Benedict, E. B.: Gastroenterology, 14:275 (Feb. 1950).

ities feel that patients with pre-pyloric ulcers and patients over 50 with symptoms of short duration should also have immediate gastric resection. In the majority of cases a therapeutic trial of a strict medical regimen is necessary to determine whether a gastric ulcer is benign or malignant, but even this is not infallible. One cannot set a definite duration for this trial period but most benign ulcers will show complete healing roentgenologically in 3 to 6 weeks. In this time there should also be a complete disappearance of all symptoms and occult blood should be consistently absent from the stools. If these criteria are not fulfilled, the patient should be operated on. Complete disappearance of a gastric ulcer under medical treatment cannot be taken as certain proof that the lesion is benign. Palmer and Humphrey[11] demonstrated vividly in pathologic material that *malignant ulcers may regress under medical treatment* with even complete repair of the tissue defect and the scar of such an ulcer may be covered by neoplastic mucosa or by a layer of normal epithelium. Hence, even after a lesion has been observed to heal under treatment the patient should be re-examined after one month and at short intervals thereafter. Any recurrence of the lesion demands immediate surgery.

SUMMARY

1. The differential diagnosis of the benign and malignant gastric ulcer may be extremely difficult.

2. Immediate surgery for *all* gastric ulcers is not a wise procedure. Each case should be treated individually after critical evaluation of all the findings obtained from the clinical, laboratory, roentgenologic and gastroscopic examinations and (where indicated) observation of the patient's response to a short but thorough trial of medical therapy.

3. When there is the slightest doubt adequate surgery should be performed immediately. The lesser evil would be to resect a benign ulcer thought to be malignant than to treat medically a carcinomatous ulcer thought to be benign.

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AN UNUSUAL CASE OF ANTEPARTUM RUPTURE OF THE UTERUS

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Rupture of the uterus is a rare complication of pregnancy. Most ruptured uteri are due to past or present manipulative or traumatic procedures. The second commonest type is a rupture in the scar marking the site of a previous caesarean section. The rarest type is spontaneous rupture of the uterus. This is usually due to excessive use of pituitrin or to failure to recognize obstructive labor. In all cases of rupture of the uterus, the maternal mortality is high, 33 to 50 per cent, and the fetal mortality is even higher, 80 to 88 per cent. Because of the frequent catastrophic outcome of this obstetrical accident, a carefully considered, yet decisive approach is needed to assure a favorable termination.

The case here presented is one of spontaneous antepartum rupture of the uterus. There was neither an excessive use of pituitrin, nor any sign of vaginal bleeding.

A thirty year old gravida-4, para-2, was admitted to the Hackensack Hospital, with a complaint of severe abdominal pain of eight hours' duration. She had had two full term spontaneous vaginal deliveries without complications. Two years before, she had an early spontaneous abortion without any history of intra-uterine manipulation or curettage. The patient did not know the exact date of her last menstrual period, but it was believed that she was now in the seventh month of her current pregnancy.

Eight hours prior to admission she had been seized with sudden colicky pain in the right upper quadrant. Dyspnea was marked. At the time of admission the pain had become generalized; the uterus was enlarged to about eight months' gestation, and was very tense on palpation. Heart sounds were normal. Blood pressure was 110/70.

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11. Palmer, W. L., and Humphrey, E. M.: Gastroenterology, 3:257 (January 1944).

Rectal examination revealed no dilatation of the cervix, nor engagement of the presenting part. Fetal heart sounds were heard in the right lower quadrant. X-ray of the chest revealed considerably increased density in both lower lobes, possibly resulting from the bilateral elevation of the diaphragm.

The patient showed symptoms of mild shock on the day following admission and was given a transfusion of 500 cubic centimeters of whole blood. An oxygen tent was used to relieve her dyspnea. Further examination failed to reveal a cause for the shortness of breath or the pain.

There was a slow steady drop in the number of erythrocytes and in the hemoglobin level. The number of white blood cells and the differential count remained within normal limits.

Two days after admission, she suddenly showed symptoms of profound shock: pale, cold clammy skin, thready pulse, and a marked fall in blood pressure to 70/50. The palpation of a movable, irregular hard mass in the right lower quadrant, seemed to indicate that the fetus had passed into the abdominal cavity. Treatment for shock and transfusion of a liter of whole blood was immediately instituted. Her condition quickly improved following these measures and her blood pressure attained its prior level of 110/70.

Immediately after her recovery from shock, a laparotomy was performed with sodium pentothal-curare anesthesia supplemented by 50 per cent nitrous oxide and oxygen. Following a midline subumbilical incision, the abdomen was opened in layers, revealing a dead fetus of eight months' gestation, together with its placenta, free in the abdominal cavity. The uterus appeared to be ischemic and contracted to the size of three months' gestation. There was a rupture 2½ inches long and 1½ inches wide, exactly in the center of the fundus. The fundus wall was 1½ inches thick. The rupture was much smaller than anticipated, because of the contraction of the uterus. A low supravaginal hysterectomy was performed. No drains were used. During the surgery the patient was given a further transfusion of 1500 cubic centimeters of whole blood.

Postoperatively antibiotics and sulfonamides were administered, chiefly as a prophylaxis against infection. As the number of erythrocytes was still under 3.5 million, another transfusion of 500 cubic centimeters of whole blood was made. The patient was ambulatory on the third postoperative day and remained afebrile for the rest of her stay at the hospital. The incision healed by primary union and the patient was discharged on the tenth day. Six months later, examination revealed a small, clean, movable cervical stump and a well healed scar.

Although rupture of the uterus is a rare complication of pregnancy, one must be alert to its possible occurrence in order to assure early diagnosis. Early diagnosis is of paramount importance. Once diagnosed, the patient should have immediate laparotomy. Adequate quantities of blood must be at hand to combat the ever present shock. Laparotomy is the treatment of choice regardless of whether the rupture of the uterus is complete or incomplete, because a more conservative approach has generally been found to have an extremely high maternal mortality.

SUMMARY

1. A rare case of spontaneous antepartum rupture of the uterus is discussed.

2. All cases of rupture of the uterus require an early diagnosis.

3. Shock must be relieved. Transfusion of whole blood is necessary in adequate quantity.

4. Immediate laparotomy is a life saving measure, regardless of whether the rupture is complete or incomplete.

74 Perry Street

COURSE IN INDUSTRIAL MEDICINE

The University of Cincinnati will accept applications for a limited number of Fellowships for physicians who wish to qualify for the practice of Industrial Medicine. Candidates who complete the course satisfactorily will be awarded the degree Doctor of Industrial Medicine. Any registered physician who has completed two years of residency (including internship) in a hospital accredited by the American Medical Association may apply for a Fellowship in industrial health. The course begins with a two-year period of intense preliminary training in the basic phases of industrial medicine followed by one year of practical experience under adequate supervision in industry. During the first two years, the stipends for the Fellowships will be between $2100 and $3000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

REMOVABLE RUBBER BANDAGE EXTENSION FOR THE EXTREMITIES †

Albert A. Schwartz, M.D., Perth Amboy, N. J.

A simple comfortable method of foam-rubber skin traction used by the author is presented. This may be used for either the upper or lower extremity, and has been used for removable traction by the author for three years. It is not a panacea to replace all other forms of extension. However, it is exceedingly useful in situations where the patient and/or physician wish an extension that is removable and which has few of the admitted disadvantages of adhesive tape for some persons. Those who wish to use this method should recognize that a delicate adjustment of pressure must be made and that frequent inspection of the extremity is required while the rubber is *in situ;* and that daily baths and alcohol rubs of the skin with replacement of the traction are desirable.

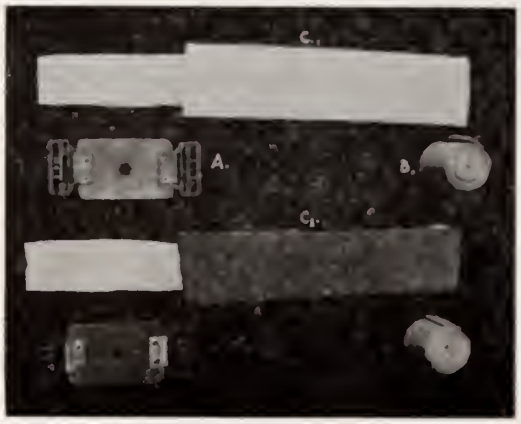

Figure 1.

Figure 2.

The conventional adhesive tape or mole skin type of skin traction is occasionally objectionable because it is not easily removed. If skin sensitivity is present, it cannot be reapplied. Some patients also complain of various types of discomfort.

This type of sponge-rubber foam traction has four advantages:

1. It is easily applied.
2. It is comfortable.
3. It is non-irritating to the skin.*
4. It is easily removed.

The materials necessary are displayed in the first figure. Keyed to the letters in the illustration, they are as follows:

A. A metal spreader.
B. A woven fabric elastic bandage.
C. A sheet of sponge rubber foam. The outer surface is shown at C and the inner surface (i.e. the face of the sheet applied to the skin) is marked C-1.

Adhesive tape is also needed, as it is applied to the outer surface of the rubber slab.

Two pieces of sponge rubber foam are cut to fit the lateral surfaces of leg or arm. For the leg, a piece is cut approximately three inches wide. This covers the area from just below the head of the fibula to just above the malleolus. A three inch piece of adhesive tape is applied to the outer surface. This is long enough to overlap one end of the sponge foam for a distance of six inches. The sponge foam is then placed next to the skin, one piece on either side of the leg. These are secured to the leg by gentle pressure secured by three inch elastic bandage. A metal spreader with two three-prong buckles is attached to the free adhesive ends and the weight then applied. See figure 2.

† From Perth Amboy General Hospital, Perth Amboy, N. J.

* Except in the unusual subject who happens to be rubber-sensitive. This is an exceedingly rare form of sensitivity.

280 Hobart Street

STATE ACTIVITIES

RESOLUTION ON THE DEATH OF JAMES F. NORTON, M.D.

Seldom in the past has the sudden death of a member of The Medical Society of New Jersey been so calamitous as is that of Dr. James F. Norton who was lost to us at the height of his career and in the period of his greatest usefulness to the Society. Dr. Norton was a man of many and varied talents. He had attained pre-eminence as a teacher and practitioner in the field of obstetrics and his professional advice and guidance were widely sought. Possessed of an unusual education in the classic languages, history and English literature, his scholarly essays had grace, beauty and lucidity. He was keenly interested in many fields aside from medicine including political economy and the science of government, general education, sociology and sports. In everything he undertook he displayed energy and enthusiasm and a mastery of minute details. His memory was phenomenal. Well grounded in logic and trained in oratory, he was a skilled and resourceful debater who regarded every dispute or argument as an intellectual challenge which he accepted with joyful zest. His versatility in this field delighted his friends and confounded his opponents. He had ready wit, subtle humor and facile satire to which he added more than a touch of the Thespian art. In debate he could transfix his adversary with lightning-like rapier thrusts or demolish him with sledge hammer blows whichever attack better suited the occasion.

Dr. Norton enjoyed the admiration and devoted loyalty of his friends and close associates and in return he was unfailingly loyal and generous to them. He earned the affectionate regard of countless patients by his expert professional care and his considerate interest in their personal welfare.

Dr. Norton served The Medical Society of New Jersey competently and faithfully for many years as a member of the House of Delegates; as a Trustee and as Chairman of the Board and in the presidential offices. He was indefatigable in his efforts to advance the welfare of our Society. He was faithful in attendance at meetings and no meeting was ever dull when he was present. Among his many activities, this Society was closest to his heart. During his presidency he conducted its affairs whole heartedly with complete disregard of his professional work, his personal welfare and certainly his health. He accepted every invitation without regard to time or distance always distinguishing himself by his speeches and bringing luster to our name. His last and greatest effort was in the expoundment of the New Jersey Plan on a national scale. His final service was to present the New Jersey Plan to the Reference Committee of the American Medical Association. Although he did not win this battle he made a deep impression upon the members of this committee by his obvious sincerity and by the clarity of his presentation. He was a valiant champion of democracy and the American way of life—a staunch Defender of the Faith of American medicine. We shall not soon again see another such as he.

Being fully aware of the irreparable loss which we have sustained by the death of Dr. Norton, the Trustees of The Medical Society of New Jersey hereby resolve:

That we record our sorrow for our loss;

That we express our appreciation and lasting gratitude for the great contribution which Dr. Norton made to the welfare of the Society; that we offer to Mrs. Norton and her family our deep sympathy in their bereavement and that this resolution be spread upon the minutes of this meeting of the Board of Trustees and that a proper copy be transmitted to Mrs. Norton.

COMMUNICATION CHART FOR APHASICS

An ingenious communication chart enabling aphasics to put across requests in simple hand-sign language is now available. To obtain one, write to Dr. Hamilton Cameron of 601 West 110 Street, New York 25. A 3c stamp to defray the return postage would be appreciated, but there is no charge to physicians for this chart.

WHO IS IN THE RESERVES?

Maybe you are and don't know it. Some authorities take the position that any one who served as a medical officer in World War II still has a comission in force, because such commissions were alive until six months after termination of the war. And as no peace treaty has been signed, World War II is still legally in existence, and therefore (presumably) any World War II medical officer commission is still good unless the doctor was retired for disability or unless his commission was affirmatively terminated. Most physician-veterans received "certificates of service" and *not* "honorable discharges"; they "reverted to inactive status" rather than "terminated their commissions". The Washington office of the A.M.A. asked the Defense Department to clarify this, and here is the answer (taken from *Capitol Clinic* number 37):

> Officer appointments or reappointments in force at the outbreak of World War II *(or made subsequently)* remain in force until six months after termination of the war or termination of the five-year appointment period, *whichever is later*, unless specific action to terminate the appointment has been taken by the Department of the Army. Under current law in this instance, World War II has not been declared terminated. As for the Navy, a doctor is still in the Naval *reserves* unless: (1) He resigned his reserve commission, or (2) he has been discharged from the reserves. The mere release to inactive duty of an officer in the Naval Reserves does not sever his connection with the Navy.

The best advice the Washington office can give then is: communicate directly with the Commanding General of the First Army (Governor's Island, N. Y.) if you served in the Army, or with the Commandant of the 3d Naval District at 90 Church Street,* New York, if you served with the Navy, and if you think you are now in the Reserves.

PRIZE FOR PAPER ON CHEST DISEASES

The American College of Chest Physicians offers a cash prize award of $250 for the best original contribution, on any phase of chest diseases. The award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College to be held in Atlantic City, New Jersey, June 7, 1951.

The College reserves the right to invite the winner to present his contribution at the annual meeting and to publish the essay in its official publication. Contestants are advised to study the format of *Diseases of the Chest* as to the length, form and arrangement of illustrations to guide them in the preparation of the manuscript.

The following conditions must be observed:

1. Five copies of the manuscript, typewritten in English should be submitted to the Executive Office of the College, 500 North Dearborn Street, Chicago 10, Illinois, not later than April 1, 1951.
2. The only means of identification of the author or authors will be a motto or device on the title page and a sealed envelope, bearing the same motto or device on the outside, enclosing the name of the author or authors.

RADIOLOGISTS' CONVENTION

Chicago is the place and December 10 to 15 the dates of the next meeting of the Radiologic Society of North America. Mornings will be devoted to practical refresher courses on all phases of radiology. Scientific papers will be offered every afternoon. High point of the convention will be a talk on cardiovascular radiology by Dr. Wendell G. Scott of St. Louis. For detailed program write to Dr. Donald Childs at the Medical Arts Building in Syracuse, N. Y.

* South Jersey residents, communicate with the Commandant, 4th Naval District, Naval Base, Philadelphia.

SHOCK RESULTING FROM BURNS

Oral Treatment During Large Scale Catastrophies

The Surgery Study Section[1] of the National Institute of Health has recommended to the U. S. Public Health Service that oral saline solutions be adopted as standard procedure in treatment of shock due to burns and other injuries during large scale catastrophies.

The first memorandum, prepared by Dr. Carl Moyer,[2] submitted in February 1950, reads as follows:

"Since publication of the experimental work of Dr. Rosenthal, Dr. Collier, *et al.*, orally administered salt solutions have been used in the treatment of burns at the University of Michigan Hospital, at the Wayne County General Hospital, and at Parkland Hospital in Dallas. Personal clinical experience has convinced me that orally administered salt solutions are valuable adjunctive agents in the treatment of shock incident to burns, fractures, peritonitis, and acute anaphylactoid reactions. Certain factors are important in governing the effectiveness of the oral administration of salt solutions. They are as follows:

"1. The composition of the salt solution: The most palatable salt solution is made by dissolving 3 to 4 Grams of sodium chloride and 2 to 3 Grams of sodium citrate in each liter of water. If sodium citrate is not available, ordinary baking soda may be substituted.

"2. The concentration of salt should not be in excess of 140 milliequivalents of sodium per liter. If the concentration is above this, vomiting and diarrhea became important complicating factors.

"3. When profound peripheral circulatory collapse is present, the intravenous route of administration must be used until peripheral blood flow has been reestablished. The salt solutions most satisfactory for this purpose are Hartmann's solution (Lactate-Ringer's solution) or plasma. In addition to the salt solution or plasma intravenously, whole blood is given concurrently wherever peripheral circulatory collapse exists. This materially implements the effectiveness of salt solutions.

"The slightly hypotonic salt solution is the only drinking fluid permitted the injured individual until the edema of the injured parts begins to subside. Certain exceptions have to be made during hot weather when it is sometimes necessary to permit some non-salty water.

"As much as 10 liters of the hypotonic salt solution have been drunk in the 24-hour period by adults who have been severely burned. Since salt solution has been substituted for water, as a drinkable fluid, no burned person who has lived for longer than three hours after being admitted to the hospital has suffered from anuria. The 'early toxemia phase' of the burns has also failed to appear and the osmotic concentration of the plasma electrolytes has been well maintained.

"More clinical observations and actual experimental work should be undertaken regarding the effectiveness of the basic principles of the supportive therapy of burns that have been so beautifully demonstrated by Dr. Rosenthal. A more active program of investigation into the relative effectiveness of simple measures to combat shock would be of extreme importance to the Armed Forces and to the civilian population in the event of another war."

The Surgery Study Section letter to the Surgeon General, dated September 16, 1950, reads as follows:

"At the January 1950 meeting of the Surgery Study Section, there was considerable discussion concerning oral saline solutions in the treatment of burns and other serious injuries. It was the consensus of the Section at that time that (on the basis of the animal work done by Dr. Rosenthal of the National Institute of Health, and the clinical work done by Dr. Carl A. Moyer, by the undersigned, and by others) the efficacy of such treatment had been definitely demonstrated. While there is need for additional research, our present knowledge is sound enough so that action can be taken on this basis. Dr. Moyer was designated to draft a memorandum on this subject. Such a memorandum was prepared and furnished to Dr. Norvin C. Kiefer, Director, Health Resources Division, National Security Resources Board, on February 15, 1950. Here is the memorandum:

"In view of the more acute national emergency that has developed since Dr. Moyer wrote this memorandum, the Study Section, at its meeting on September 16, 1950, voted to recommend that the principles of treatment outlined in his memorandum be adopted for widespread use in any large-scale disaster involving the civilian population. Because of the present emergency situation, we have modified the last paragraph of Dr. Moyer's memorandum to read, 'While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population.' "

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1. Personnel of this Surgery Study Section are: Doctors Frederick Collier, Claude S. Beck, Loren Chandler, Lester Dragstedt, Daniel Elkin, Carl Moyer, Harris Shumacker, Jr., Owen Wangensteen, Allen Whipple, H. L. Skinner, Henry Beecher, J. Gordon Lee, Howard R. Lawrence, Francis E. Warren and G. Halsey Hunt.

2. Professor of Surgery, Southwestern Medical School, University of Texas.

WELFARE COMMITTEE MEETING

SEPTEMBER 17, 1950

This was the first business meeting of the Welfare Committee for the 1950-51 administrative year. It was attended by 36 Committee members from 19 county societies. Visitors, Advisory Committee Chairmen, Trustees, County Society Presidents and County Society Chairmen of "Public Health Week"—brought the total attendance to 56.

President Crowe briefly reviewed the activities during the summer months, particularly with relation to Civilian Medical Defense and Procurement and Assignment.

REPORTS OF SUBCOMMITTEES

Public Relations — Dr. Joseph E. Mott, Chairman.

At the morning meeting of the Subcommittee, the proposed activities for the year as discussed at the June meeting were reviewed.

1. Designated members of the Committee will arrange conferences with county public relations and executive committees with respect to furtherance of the State Society's programs.

2. State-wide Press Conference has been set for Friday, October 20 at Trenton. This will be a two and one-half hour session and all newspaper editors and representatives will be invited and it is expected that the conference will bring about good publicity for "Public Health Week".

3. Round-the-clock emergency service has been on the program of the Committee for some time. Thirteen of the larger counties have a good emergency service program working. Smaller counties composed largely of general practitioners have reported that the need for round-the-clock services does not exist. The Committee feels that the state as a whole is well covered.

Legislation—Dr. C. Byron Blaisdell, Chairman.

Reorganization Plan No. 27 was defeated in the House. Congressman Wolverton has sent two bills, H.R. 8746 and H.R. 9128, to the Society with the request for opinion. The Committee is studying these two bills at this time.

At the morning meeting of the Committee discussion centered on the chronically ill, the Chiropodists, and the question of corporate practice of medicine, which matter was referred to the Committee for study by the Board of Trustees. The Committee recommended that the question of corporate practice of medicine be referred to Mr. O'Mara to define the corporate practice of medicine and to draw up legislation that can be introduced in the next session.

Medical Practice — Dr. Albert B. Kump, Chairman.

The Subcommittee has recommended to the Advisory Committee on Laboratory Medicine for study:

1. Improve and enlarge upon the code for embalmers, hospitals and pathologists.

2. Draw up a standard autopsy permit to be used throughout the state.

3. Investigate laws on the problem of disposal of parts of bodies.

4. Establish a definition of the law pertaining to pre-marital tests in order that there be mutual understanding between the laboratories, the public and the physicians.

5. Establish basic requirements and methods of control of lay laboratories.

The Subcommittee has recommended to the Advisory Committee on Physical Medicine that it study and make specific recommendation on:

1. The establishment of definite regulations concerning the Physiatrist and his department.

2. That every department of Physical Medicine be headed by a Physiatrist.

The subject of hospital corporate practice as impingement on private practice of medicine is under study by the subcommittee and its Advisory Committees. Also, the Committee has under review a study regarding corporate practice.

Definitions have been requested regarding Compulsory Consultation in Obstetrics and abnormalities as established by the Maternal Welfare Committee. Specific action will be based upon these definitions and the attitude of Medical-Surgical Plan regarding payment of these Compulsory Consultations.

Public Health — Dr. Joseph I. Echikson, Chairman.

The Welfare Committee approved the recommendation and recommends its adoption by the Board of Trustees that the Society co-sponsor the, "1951 Work Shop on Health Education," planned by the New Jersey Tuberculosis League.

The Welfare Committee approved the recommendations of the Advisory Committee on Conservation of Vision and Hearing and recommends their adoption by the Board of Trustees:

(1) That parents of pre-school children be encouraged to have their children's eyes examined prior to the usual pre-school examination at the age of 5. Certain eye conditions discovered in the pre-school examination could be remedied or corrected if the child had been examined a few years earlier.

(2) Disapproval of the request of the New Jersey Optometric Association that medical eye practitioners fill in the questionnaire indicating their qualifications to practice this specialized field. The Advisory Committee disapproves of the idea in principle that a nonmedical group seeks to judge the qualifications of medical men. It is felt that this is entirely a function of the medical profession and there is available to all non-medical groups adequate material indicating the qualifications of medical men in any particular field. The Committee recommends that the Society be advised not to fill out such a questionnaire.

At the morning meeting of the Subcommittee an exhibit prepared by the Woman's Auxiliary demonstrating the Four-Point School Health Program was approved for showing at the convention of the New Jersey Education Association, November 9 to 12, in Atlantic City. The expenses of approximately $35.00 per booth and incidentals will be allotted from the Public Health Committee budget.

The 1950 Annual Report of the Advisory Committee on Child Health was referred back to the Committee for further study and specific recommendation. The revised report of the Child Health Committee in offering to the county medical societies a pediatric consultation service was approved by the Subcommittee. The full report was read to the Welfare Committee, which also gave its approval.

The Subcommittee approved the recommendation of the Advisory Committee on Adult Disease Control that the article, "Obesity as a Problem in Preventive Medicine," which appeared in the United States Armed Forces Medical Journal, be published in the JOURNAL of The Medical Society of New Jersey.

1950 "PUBLIC HEALTH WEEK"

The week of November 13 to 18 has been designated as "Public Health Week". In accordance with the action of the House of Delegates last May, co-sponsors of "Public Health Week" will be the Woman's Auxiliary and the state and local health departments. Other agencies will be invited to take part as cooperating rather than co-sponsoring. Eighteen of the twenty-one county societies have designated a committee for "Public Health Week" and an outline of suggestions has been sent to the county committees. Arrangements are being made with Governor Driscoll to proclaim "Public Health Week" by public proclamation as he did in 1948. County societies are requested to ask the Board of Freeholders and the Mayors of prominent cities to make similar proclamations early in November.

TRUSTEES' MEETING

OCTOBER 1, 1950

The regular meeting of the Board of Trustees was held on October 1, 1950, and the following actions were taken:

(1) The Trustees authorized the establishment of a special committee on Civil Medical Defense the members to be appointed by the President. Dr. Crowe designated Dr. A. F. McBride as chairman. Other committee members are:

Dr. David B. Allman, vice-chairman; Dr. Gerald W. Sinnott, Dr. Daniel Bergsma, Dr. Stuart Z. Hawkes, Dr. Stewart Alexander, Dr. Ruffin Stamps; Dr. Aldrich C. Crowe, Ex-Officio; Dr. Sigurd W. Johnsen, Ex-Officio; Dr. Harrold A. Murray, Ex-Officio, and Dr. Henry B. Decker Ex-Officio.

(2) The Trustees authorized the establishment of a special committee on Procurement and Assignment, the committee to be appointed by the President.

President Crowe announced the committee would be composed of:

Dr. William G. Herrman, Chairman; Dr. L. Samuel Sica, Vice-Chairman; Dr. Albert B. Kump, Dr. Frederick S. Taber, Dr. F. Clyde Bowers, and Dr. Andrew F. McBride.

(3) The Board validated the actions taken on Civil Medical Defense and Procurement and Assignment during the summer months.

(4) The Judicial Council's recommendation to the County Societies for enactment of a uniform by-law to implement the Society's program for adjudication for disputes and complaints against physicians was approved.

The Trustees further recommended to the County Societies that they change their by-laws in accordance with these recommendations.

(5) Upon request of the Judicial Council a special budget allotment of $500 for expenses of the Council was approved.

(6) The report of the Welfare Committee was approved.

(7) The Medical Education Committee proposed the establishment of a graduate program to be operated from funds raised from outside sources. The Medical Society of New Jersey will not be obligated financially.

The Trustees approved the proposal of the Committee on Medical Education to employ an executive secretary to carry out its policies and directives. Funds for such purposes are to be derived entirely from sources outside The Medical Society of New Jersey.

(8) The report of the A.M.A. Delegates reviewing the 1950 annual session in San Francisco, June 26 to 30, 1950, was approved.

(9) By decision of the Section Officers the Scientific Program for the Annual Meeting will be consolidated into two general sections, medicine and surgery. The individual sections will retain their identity.

The Board approved this consolidation and the following program schedule:

MONDAY, MAY 14, 1951

9:30 a.m.-12:30 p.m.—Scientific Program in Medicine. Scientific Program in Surgery.
12:30 p.m.-2.30 p.m.—Group Luncheons and Business Meetings.
2:30 p.m.-5:30 p.m.—Scientific Program in Medicine. Scientific Program in Surgery.
5:30 p.m.—Group Dinners and Business Meetings.
8:30 p.m.—Nominating Committee.

TUESDAY, MAY 15, 1951

9:30 a.m.-12:30 p.m.—House of Delegates.
12:30 p.m.-2:30 p.m.—Group Luncheons and Business Meetings.
2:30 p.m.-5:30 p.m.—Scientific Program in Medicine. Scientific Program in Surgery.
5:30 p.m.-8:30 p.m.—Group Dinners and Business Meetings.
8:30 p.m.—Public Meeting on Civilian Medical Defense Reference Committees.

WEDNESDAY, MAY 16, 1951

9:00 a.m.-12:00 noon—Scientific Program in Medicine. Scientific Program in Surgery.
12:00 noon-1:00 p.m.—House of Delegates (election).
2:00 p.m.-5:00 p.m.—House of Delegates.
7:00 p.m.—Dinner-Dance.

(10) Upon recommendation of the special committee the audit report on the Treasurer's books for 1949-50 was approved.

(11) The report of the Special Committee on Implementation of the "New Jersey Plan" outlined the action of the A.M.A. House of Delegates in June on the Plan. Subsequent to the meeting of the House of Delegates, the A.M.A. Board of Trustees appointed three of its members as a committee to study the 12 Point A.M.A. Program.

The recommendation of the Committee was approved that the Board of Trustees of The Medical Society of New Jersey should communicate with the chairman of the Special Committee of the Board of Trustees of the A.M.A. expressing New Jersey's interest in the problem facing the Committee charged with the task of "augmenting and clarifying" the A.M.A. 12 Point Program; that if the Committee contemplates holding any Committee hearings on this matter our Society would appreciate the opportunity of appearing before the Committee to present our point of view on possible modification of the A.M.A. 12 Point Program.

(12) By unanimous action, Dr. Irving P. Borsher was employed on a part time basis as Medical Director, Distribution of Medical Care, to succeed Dr. Norman M. Scott.

(13) The Board unanimously nominated Dr. Irving P. Borsher for membership on Board of Trustees of Medical-Surgical Plan.

(14) The Board acceded to the request of Medical-Surgical Plan for the release of Mr. Bryan from the position of Executive Officer of The Medical Society of New Jersey so that he could assume the position of administrator of Medical-Surgical Plan as of November 1, 1950.

Mr. Bryan tendered his resignation as Executive Officer, which was accepted by the Board with regret, and a vote of appreciation for the excellent service he has given the Society during the last three years.

(15) Dr. Johnsen, Dr. Murray and Dr. Decker were appointed to explore the possibility of securing the service of another executive officer or public relations officer in lieu thereof.

(16) The Trustees authorized a letter to the county societies informing them of the year round effort to aid in obtaining suitable employment for physically handicapped people and urging that the county societies designate representative physicians to serve on the local committees in their respective counties.

(17) Fifteen county medical societies have appointed local committees to cooperate in the program on Temporary Disability Benefits. The Trustees authorized sending a communication to the remaining six county societies again urging the appointment of local committees.

(18) Dr. L. Samuel Sica, Trenton, was unanimously elected to fill the unexpired term of Dr. Norton as A.M.A. delegate.

(19) The Trustees authorized the purchase and erection in the State Headquarters Building of a memorial plaque to Dr. Henry C. Barkhorn. The location of the plaque to be left to the House Committee.

(20) At the close of September, 65 per cent of the membership had paid their dues to the A.M.A. Representation to the A.M.A. House of Delegates in 1951 will be based on the paid membership of 1950.

The Trustees authorized the rebilling of those members who have not paid their 1950 A.M.A. dues and recommended to the State Treasurer that a letter be enclosed similar to the one previously sent stressing the point that the number of delegates to the A.M.A. will be based on the number paid.

(21) Dr. Vincent P. Butler was unanimously elected to succeed Dr. Norton as a representative of The Medical Society of New Jersey on the Governor's Commission for the Study of a Medical School in New Jersey.

(22) A resolution on the death of Dr. Norton was unanimously adopted. (See page 527.)

SUPPLEMENTARY LIST No. 7 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

DeRosa, Vincent A., 31 Oakwood av.,L'g Branch(13)
Gadomski, Joseph, 245 S. Wood av., Linden (20)
Guthrie, Wilson G., 550 Parker st., Newark (7)
Husik, Franklin B., 101 Main st., S., Glassboro (8)
Moretti, John J., 18 Ivanhoe ter., E. Orange(7)
Nicas, Allen M., 450 Broadway, Long Branch (13)
Pasquale, Thomas L., 92 High st., Orange (7)
Riggins, Edwin N., 161 N.Arlington av.,E.Orange(7)
Rubin, Henry S., 11 High st., Morristown (14)
Samuel, Jerome H., 61 Lincoln Park, Newark (7)
Vaccaro, Henry J., 509 Fourth av., Asbury Park (13)
Wanger, William F., 539 Mt. Vernon Blvd., Royal Oak, Michigan (7)
West, Harold, 606 F st., Belmar (13)
White, Ensley M., Jr., 118 Branch av., Red Bank(13)

ASSOCIATE MEMBERS

Ayres, John R., Jr., 140 River rd., Red Bank (13)
Denholtz, Myron, 133 Chelsea av., Long Branch (13)
Mazza, James G., 333 Chelsea av., Long Branch (13)

INDUSTRIAL MEDICINE LECTURES

Columbia University announces lectures on industrial medicine to be given from 9 to 10 o'clock on Saturday mornings beginning on December 9, 1950. The lectures will be given in Amphitheater A, College of Physicians and Surgeons, 630 West 168th Street, New York.

All physicians are invited to attend. There will be no formal registration and no tuition fee. The schedule is as follows:

December 9—History of Industrial Medicine.

December 16—Objectives and Practice of Industrial Medicine.

January 6—Industrial Toxicology.

January 13—Toxic Metals I.

January 20—Toxic Metals II.

January 27—Toxic Solvents.

February 3—Toxic Dusts.

February 10—Toxic Gases.

February 17—Occupational Dermatoses and Infections.

February 24—Ventilation, Lighting, Noise.

March 3—Elementary Nuclear Physics: Radiation Hazards.

March 10—Workmen's Compensation.

GRADUATE WEEK OF THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

DECEMBER 11 TO 15, INCLUSIVE

Plans have been completed for a full week of hospital clinics, panel discussions, scientific exhibits and evening lectures by prominent authorities as part of the graduate program of the Academy of Medicine of Northern New Jersey, for the week of December 11, 1950.

The subject of the week will be recent advances in diagnosis and treatment. Admission will be free to all members of the medical and dental professions.

The program will include operative and medical clinics at ten hospitals in northern New Jersey. Each hospital has arranged instructive programs for two days of the week so that only four hospitals will have programs on any single day. Scientific exhibits will be set up at the participating hospitals.

Afternoon panel discussions will consider recent advances in the diagnosis and treatment of peripheral vascular disease, including the use of coagulants; Cortisone and ACTH; treatment of cancer, and both moderators and panel members will be well-known authorities in these fields.

The evening lectures will be sponsored by various scientific organizations and will open with The Harrison S. Martland Lecture, Monday, December 11, on pathogenesis of atherosclerosis. The speaker will be G. Lyman Duff, Professor of Pathology and Dean of the Faculty of Medicine, McGill University, Toronto, Canada.

Tuesday, December 12, the subject will be recent advances in surgery of the diabetic by Gerald Pratt; and diagnostic features of pancreatic disease by J. Edward Beck.

Thursday, December 14: preventive aspects of rheumatic heart disease, by David D. Rustein, Professor of Preventive Medicine, Harvard University; and surgical aspects of congenital heart disease by Charles P. Bailey, Professor of Thoracic Surgery, Hahnemann Medical College.

Friday, December 15: adrenal hormones, leukemia and lymphomas, by Olaf H. Pearson, Memorial Hospital, New York; and treatment of breast cancer by Frank Adair, Memorial Hospital, New York.

Detailed programs of the week's activities will be sent to all Academy Fellows. All hospitals in New Jersey will receive copies for posting on bulletin boards. Physicians and dentists may obtain a copy of the program by addressing a request to the Academy of Medicine, 91 Lincoln Park, Newark.

OBITUARIES

DR. MARTIN S. MEINZER

Dr. Martin S. Meinzer, 72, of Perth Amboy, died on September 15, 1950.

Dr. Meinzer received his medical degree in 1905 at Columbia University College of Physicians and Surgeons. He interned at Orange Memorial Hospital, and established the general practice of surgery in Perth Amboy in 1906. He was a member of the staff and a visiting surgeon at the Perth Amboy General Hospital until his retirement in 1946. He was a Fellow of the American College of Surgeons, and had served as school physician for eight years, as city physician for nine years and physician to the Perth Amboy Board of Health for one year.

DR. SIMON F. WADE

Dr. Simon F. Wade, emeritus member of the Union County Medical Society and The Medical Society of New Jersey, died on September 9 at his home in Milford, Pa.

Dr. Wade was born at Hackettstown in 1883 and received his medical degree from Columbia University College of Physicians and Surgeons in 1909. He interned at Bellevue Hospital, New York. He once served as medical inspector in the Elizabeth public school system.

DR. DAVID E. WARREN

Dr. David E. Warren of Passaic died on July 14, 1950.

Born in Canadaigua, New York, in 1868, Dr. Warren was graduated from the College of Physicians and Surgeons, Baltimore, and from the University of Buffalo. Shortly after graduation he was superintendent of the Kings County Insane Asylum, New York. He was a World War I veteran and was a Diplomate of the American Board of Neurology and Psychiatry, heading the neuropsychiatric staffs of both St. Mary's and the Passaic General Hospitals for many years. He was on the Advisory Board of the Children's Bureau in Passaic and for many years was county psychiatrist.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

NOVEMBER 13-18 IS PUBLIC HEALTH WEEK

November 13 to 18 is being observed as Public Health Week in New Jersey as a result of a proclamation issued by Governor Alfred E. Driscoll.

The Governor's proclamation, the text of which appears below, calls attention to the fact that effective local public health administration is an indispensable basis for effective civil defense.

The current recognition of Public Health Week also points up the work of the Governor's Committee on Local Health Administration, which was mentioned in the proclamation. The Committee has worked for eight months to determine what the deficiencies of local public health administration in New Jersey are and the best ways to remedy them. The Committee is expected to propose legislation which would make it possible for New Jersey communities to strengthen and improve local public health administration.

The text of the Governor's proclamation follows:

PROCLAMATION

WHEREAS, The Medical Society of New Jersey has initiated the observance of Public Health Week during the period of November 13 through November 18, 1950; and

WHEREAS, medical arts and science have made tremendous strides in unearthing the secrets of nature and providing us with ever more effective methods of keeping people healthy and enabling everyone to live a fuller life; and

WHEREAS, a public health week represents a joint effort of the medical profession, the allied professions of dentistry, nursing and pharmacy, hospital administrators, the departments of health and voluntary agencies engaged in health and welfare work, to interpret the advance in medical science to the people of our State, to make us more conscious of health problems and to acquaint us with the resources in each community that stand ready to help preserve individual health or minister to those who are taken sick or disabled; and

WHEREAS, the Governor's Committee on Local Health Administration is currently studying local public health administration in New Jersey with a view to recommending ways to make it more effective; and

WHEREAS, effective local public health administration is an indispensable basis for effective civil defense; and

WHEREAS, experience has shown that community health councils have proven effective in arousing citizen participation and support in the solution of health problems; and

WHEREAS, a working partnership of physicians and allied professions of New Jersey, and the State and local health departments and other health agencies can build greater and greater gains in the fight against disease and premature death, and will also serve to show the citizens of our State how, through individual and community efforts, they may continue to raise the level of health in New Jersey:

NOW, THEREFORE, I, ALFRED E. DRISCOLL, Governor of the State of New Jersey, do hereby proclaim the period of November 13 to November 18, 1950, as Public Health Week, and I urge all citizens and public and private agencies concerned with public health to devote this week to an inventory and promotion of State and local health facilities.

I recommend that communities give serious consideration at this time to the formation of community health councils.

I further urge all local medical and health agencies to undertake, during this Public Health Week, to provide the broadest possible understanding of their local facilities and services for health protection and medical care.

ALFRED E. DRISCOLL,
Governor.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, September 8, at 9 p. m., Dr. G. Ruffin Stamps presiding.

Dr. John C. Leonard, director of Medical Education and Clinical Director of Hartford Hospital, Hartford, Connecticut, was the guest speaker. His subject, "Collagen Disorders", embraced a field of medicine the mechanism of which is little understood, diagnosis difficult, and treatment only recently rendered less hopeless by the addition of ACTH and cortisone.

The minutes of a special meeting of the Executive Committee, held on August 29, were read to the Society. A point of order was raised by Dr. Allman as to the propriety of having replaced Dr. Konzelmann as Delegate and as Alternate Nominating Delegate. This was done because of Dr. Konzelmann's departure from Atlantic County. After short discussion, it was moved and seconded that that portion of the minutes dealing with the replacement of Dr. Frank W. Konzelmann as Delegate and Alternate Nominating Delegate to the State Society be deleted from the records. Motion carried.

Dr. Murray, reporting for the Red Cross Blood Program Liaison Committee, and in reply to an inquiry from the State Society as to an estimate of the possibilities of immediate expansion of the program in case of emergency, stated that the Atlantic City Hospital is now supplied with Red Cross equipment to bleed donors, and in an emergency, approximately one hundred donors could be bled daily at the institution.

The Board of Censors approved for membership the following applications: For Associate membership—Dr. Walter T. Bew, Jr.; for Regular membership— Drs. Samuel C. Rosen, Herbert D. Axilrod and John W. Holland. Upon a vote of the Society, all were elected and welcomed by the president.

Dr. Allman, whose appointment as chairman of the Local Committee on Arrangements for the 1951 Session of the A.M.A. was confirmed by the A.M.A. Board of Trustees, announced that unless any member wished to be appointed to any special committee he planned to make essentially the same appointments as in the 1949 session. He stated that the 1953 convention had already been lost to New York, and added that even to secure the 1955 meeting would require energetic work and continued cooperation from everyone.

A letter from Mrs. Clarence B. Whims, president of the Woman's Auxiliary to the Medical Society of Atlantic County, pledged the support and cooperation of her organization, and outlined the extensive program which she has planned for the coming year. Dr. Stamps commented on the fine work that is being done by the Auxillary, and stated that it should be a pleasant duty for the Society to assist in whatever manner possible.

Dr. Peter Marvel read to the Society a resolution commemorating the passing of a beloved and an esteemed colleague, Dr. Stanley McGeehan. It was moved and seconded that the resolution be adopted and spread on the minutes of this Society.

A memorandum from Dr. William J. Herrman, Chairman of the State Procurement and Assignment Committee, was brought to the attention of the members. It stated, in essence, that a classification card in the form of a double postal card will be mailed to each doctor, whether or not he is a member of the State Society, on or before September 15. Both cards must be filled out; one to be mailed back to the State Headquarters and the other to be returned to the local Society.

Dr. Stamps announced that 72 per cent of the members of this Society have paid the A.M.A. dues, a pleasing percentage, but one which he felt sure could be improved upon.

Dr. Timberlake, commenting on the recent death of Assemblyman James E. Fraser, stated that the Society had lost not only a personal friend, but a zealous guardian of medical interests in high legislative circles. He suggested that recognition of this, and appreciation of his friendship, be shown by this Society, and he accordingly moved that a letter of condolence be sent to Mrs. Fraser. The motion was seconded by Dr. Allman and carried.

The president brought to the attention of the Society the question of its participation in a nation-wide newspaper advertisement, to be run the week of October 8, in papers all over the country, concerning the National Educational Campaign. This gigantic spread will feature mats sponsored by medical societies and numerous allied professions and businesses. The discussion was summed up by Dr. Allman, who stated that there should be no question of participation, that this type of advertising is entirely ethical, and that, above all, we should not lose sight of the fact that this is our fight. He therefore moved that it be the opinion of the Society that it should participate in this campaign, and that the nature of it be left to the discretion of the president. The motion was seconded by Dr. Peter Marvel, and carried.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on September 14, at the Riverton Country Club. This was the first meeting since spring, and our new president Dr. Betts was on hand to welcome all of us.

The scientific part of the program was presented by Dr. Henry B. Decker, professor of Dermatology at the Jefferson Medical College. He gave a very interesting talk on "Cutaneous Symptoms in Certain Systemic Diseases'".

The president told of the meeting at Atlantic City

at which all society presidents and secretaries were present. The plans regarding Procurement and Assignment which they worked out were discussed. A committee for each county headed by a chairman was considered to be the best plan to follow. The committee for Burlington County is headed by Dr. Haldeman, aided by Drs. Le Favor and Hornberger. The committee report will be ready by the next meeting at the latest.

The committee for Civil Defense was explained, and the following appointments were made:

Radiation Burns and Sickness—Dr. Oppenheimer.
Traumatic Amputation Service—Dr. Summey, as chairman aided by Drs. Davis and Metzer.
Integrated Medical Services—Dr. Buckley.
Physical Resources Committee—Dr. Metzer.

It was announced by the president that Burlington County heads the list with the greatest number to date having paid the annual A.M.A. dues.

Dr. Bray, chairman of the Public Relations Committee, announced that they are planning to stress three things, namely: an efficient speakers bureau, Public Health Week, and a 100 per cent participation in the 24 hour emergency service for the communities.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The first regular monthly meeting of the *Camden County Medical Society* for the 1950-1951 season was held at 9 p. m., October 3, 1950, at the Dispensary Building with President O. R. Kline presiding.

Dr. L. K. Ferguson, professor of Surgery, Women's Medical College of Philadelphia, was the speaker of the evening. Dr. Ferguson presented an instructive address on *Ulcerative Colitis* using many slides illustrating the pathology of the condition and explaining the surgical technic. The paper was well received and gathered favorable comment by numerous members from the floor.

New Committee appointments were announced by Dr. Kline. Dr. Walter Crist was appointed as chief of the Emergency Medical Service in the Camden Civilian Defense Unit. The Procurement and Assignment Committee designated by the president consisted of Dr. R. L. Sharp, chairman, and Drs. D. F. Bentley, Jr., and A. M. K. Maldeis.

The chairman of the Public Relations Committee, Dr. E. R. Ristine, asked the Society for the cooperation of the members in accepting requests to talk before lay groups, particularly during Public Health Week in November. He also urged the members of the Society to supply contributions in the way of literary material for the Society's monthly Bulletin.

A testimonial to Dr. Joseph E. Roberts, deceased, was read by Dr. R. S. Gamon. Dr. A. B. Davis read a memorial upon the passing of Dr. John E. L. Van Sciver. It was resolved that copies of these memorials be spread upon the minutes of the Society and copies sent to the members of the bereaved families.

Dr. H. D. Barnshaw was appointed chairman of the committee to solicit the doctors' contributions to the Community Chest for the coming drive.

The president urged all members to pay their A.M.A. dues, and stated that the representation of The Medical Society of New Jersey, insofar as delegates to the A.M.A. is concerned, will be based upon the percentage of payment of these dues.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The first fall meeting of the *Cumberland County Medical Society* was held October 10, 1950, at Richards' Farm, Bridgeton.

Dr. Carl Ware, president of the Society, read the applications for membership of Dr. Horace J. Ettinger, Vineland, and Dr. Anthony E. Chmelewski, Millville. Both were elected to the Society.

Julian Johnson, M.D., D.Sc. (Med.), F.A.C.S., presented an informal talk on *The Present Status of Thoracic Surgery.* He supplemented this with projection slides. Much, if not all, of the chest pathology has ben influenced by the traumatic surgery during the last war. The progress of this branch of surgery has been rapid, and the older treatments are being revised.

It was brought to our attention that a cardiac clinic now exists at St. Michael's Hospital, Newark, N. J., for the examination of children with heart disease. This consulting service is to augment medical treatment with surgical procedures.

Dr. E. C. Green is in charge of a Ladies' Night Dinner Dance to be held October 25, 1950, at the Owens-Illinois Club Rooms, Bridgeton. The Honorable H. Alexander Smith, Senator from New Jersey, will be our guest speaker.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

A. Guy Campo, M.D., presided at the regular monthly meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, September 21, 1950. In accordance with established policy the scientific portion of the evening was first. Theodore Eberhard, M.D., associate professor of Radiology and coordinator of Oncologic Teaching at Jefferson Medical College of Philadelphia, spoke on "Atomic Medicine". Dr. Eberhard dealt mostly with the radio-active isotopes and their present and potential uses in medicine.

During the following business session Dr. Hughes spoke in behalf of the Red Cross Blood Program. Then Dr. Wendell Burkett discussed in detail the Procurement and Assignment Service and how it would affect the physicians in Gloucester County. He also urged all men to send back their cards to the state and county societies.

Dr. Oram Wood was named an emeritus member of the Society, such action having been taken by the state society in May. Drs. Francis H. Weiss of Woodbury, and Charles D. Foster of Pitman were elected to membership in the Society.

Dr. Louis K. Collins reporting for the Program Committee stated that the Philadelphia Inquirer columnist, Ivan Peterman, would be the guest speaker at the October Ladies' Night and Social Session. A steak dinner and music by the famed La Gitana Trio was announced for the affair.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

With Dr. Noah Meyerson presiding, the *Hudson County Medical Society* held its initial meeting of the 1950-51 official year at Murdoch Hall, Jersey City Medical Center, on October 3, 1950.

The following reports were received and approved: Committee for Postgraduate Medical Education and the Diabetes Committee.

The following announcements were made:

American Cancer Society Service Committee—A communication from Mrs. Andrew C. Ruoff, described the work of the various Hospital Service Units in supplying dressings to indigent cancer patients and requested that the doctors be informed of this service in order that her Committee could be put in touch with patients requiring it.

Hobby Show, November 8—Dr. Perkel requested that all interested in exhibiting hobbies get in touch with him immediately.

Supper Dance—Medical Society—Woman's Auxiliary—Dr. Meyerson announced that the Supper Dance now being arranged by the Auxiliary will be held on November 29, 1950, at the Waldorf-Astoria Hotel. It will be the first affair of this nature under the joint sponsorship of the Society and its Auxiliary.

American Heart Association—Members were invited to attend the organizational meeting of the recently formed county Chapter of the New Jersey Heart Association, to be held at Murdoch Hall on October 10.

Dr. John L. Varriano was appointed to complete the unexpired term of Dr. Gleeson on the Board of Trustees.

Dr. James F. Norton—Eulogy—Dr. Butler paid a solemn tribute to the character and accomplishments of his lifelong friend and our distinguished member and past-president, whose recent death shocked the community.

Introduced by Dr. Samuel A. Cosgrove, the guest speaker of the evening was Dr. Emil Novak, professor of Gynecology, Johns Hopkins University School of Medicine, Baltimore, Md. Dr. Novak spoke on *The Use and Abuse of Endocrine Therapy During the Menopause.*

Immediately prior to adjournment, the meeting was addressed briefly by Dr. J. F. Londrigan, chairman of the Non-Partisan Allied Professions Committee. He reminded his hearers of their moral obligation, as physicians, to cast their vote in the coming elections of November 7. He announced that the Committee would hold two important open meetings—on October 11 in Newark and in Trenton on October 12.

MIDDLESEX COUNTY

Martha F. Leonard, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was convened by Dr. H. P. Fine, on October 18, 1950, at Roosevelt Hospital.

Dr. George M. Benko of Perth Amboy, and Dr. Edward J. Novak of Woodbridge were advanced from Associate to Regular membership. Dr. George Henderson of Bound Brook was elected to Regular membership on transfer from Somerset County Medical Society and Dr. Robert Freeman and Dr. Hugh Williams, both of Highland Park, were elected to Associate membership.

Dr. Fine appointed as nominating committee Dr. Malcolm Dunham, Dr. Sol Gurshman and Dr. Fred Taber. A General Practitioners' Committee was also appointed with Dr. Ivan Smith as chairman and Dr. S. Becker, Dr. S. Gadek, Dr. M. Dunham, Dr. I. Rineberg, and Dr. S. Gurshman as members. Dr. Shangold reported on the success of the dinner-dance given last month to honor Dr. Ira Spencer as New Jersey's Practitioner of the year, and Dr. Spencer's letter of appreciation was read.

Dr. Kohut, treasurer, reported on the society's financial status and budget for 1950. He reported that 148 (70 per cent) of the members have paid their $25 A.M.A. dues.

Dr. Fine announced that the November meeting would be deferred to November 22, because of Public Health Week, November 13-18. At the December meeting Mr. John B. Kennedy is to be speaker.

Deaths of two members, Dr. John Smith and Dr. Martin Meinzer, were announced, for whom suitable resolutions will be drawn up.

Plans for Public Health Week were presented by Dr. J. D. Witmer, Dr. Shangold for the Perth Amboy area and Dr. F. M. Clarke for the New Brunswick area. The Perth Amboy display will be based on the theme "Disaster" and will feature exhibits by the hospital, Red Cross, police, and many other agencies, portraying prevention, emergency measures, and follow-up. In the New Brunswick district U. S. Army films on bombing and atomic injuries will be shown.

Reporting for the Committee on Metabolic Disorders and Nutrition, Dr. C. Church announced that November 13-18 is also Diabetic Detection week. In Middlesex County diabetes detection has been combined with the tuberculosis case finding program, with positive findings being reported to the patient's physician.

Dr. Marshall Smith reported on the work of the Medical Defense Committee, on communications, transportation, and standardization of emergency procedures. Communication plans are being worked out with the cooperation of radio station WCTC and the amateurs of the Americal Radio Relay League. Transportation can be supplied by ambulances with two-way radio. Under the auspices of the New Jersey First Aid Council, Inc., a First Aid College has been established with eight two-hour lectures on such subjects as asphyxia, communicable disease, burns, and head injuries. Assignment of doctors is nearly complete. Each doctor will receive a pamphlet explaining the program.

A letter was read from Mr. Samuel Convery requesting appointment of Dr. S. Gadek as chairman of the Medical and Nursing Aid Committee of Disaster Service for the Perth Amboy-Carteret Chapter of the American Red Cross. This appointment was approved by the Society.

The scientific address, presented by Dr. J. M. Carlisle, Medical Director of Merck and Co., was on "Clinical Applications of Cortisone".

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on September 19, at 9:00 p. m. at the Woman's Club, Paterson. JOHN E. LEACH, M.D., president, presided at the meeting.

The following physicians were elected to Active membership: JOSEPH BORN, Lincoln Park, PETER H. SHERSHIN, Clifton, ERNEST E. JOHNSON, Passaic, and A. FREDERICK SHEPTNER, E. Paterson. CARL J. SCHOPFER, M.D., of Bloomfield, was elected to Courtesy membership. Ten physicians were elected to Associate membership: CHRISTOPHER T. REILLY, E. Paterson, HAROLD J. SARGENT, Newfoundland, JOHN W. RATCLIFFE, Wayne, JOHN J. CASTRONUOVO, Paterson, GEORGE V. BRANIGAN, Oakland, JAMES B. MEARNS, Hawthorne, PETER C. HOFSTRA, Paterson. WILLIAM J. VAN VOOREN, Clifton, MILTON ZIMMERMAN, Clifton, and EUGENE A. REILLY, Paterson. Dr. Graham, treasurer, presented the recommendation of the Welfare Council as to the dues for 1951. Motion was made, seconded and passed by the members that the dues for 1951 be set at $55.

Resolutions on the deaths of Henry Cogan, M.D., and David E. Warren, M.D., were read and adopted unanimously.

Mrs. Richard J. McDonald briefly addressed the members, relative to the survey of the chronically ill in the County to be conducted October 9 to 21.

The Community Chest Drive was discussed by Dr. Leach who requested that the members cooperate and support the voluntary hospitals and agencies. He announced the appointment of a committee, of which Dr. Graham is to be chairman, to aid the Chest.

Dr. Floyd Fortuin, secretary, introduced the speaker of the scientific session, ISRAEL S. WECHSLER, M.D., professor of Clinical Neurology at Columbia University College of Physicians and Surgeons, neurologist at Mount Sinai Hospital, attending neurologist at Neurological Institute, member American Board of Psychiatry and Neurology, American Neurological Association, American Psychiatric Association, and the Association for Research in Nervous and Mental Diseases. Dr. Wechsler's subject was "Virus Diseases of the Central Nervous System". Open discussion followed Dr. Wechsler's address with Doctors Wassing, Morrow, Urie and Morrill taking part.

Dr. Leach notified the members of the work being done relative to Procurement and Assignment for the Armed Forces, stating that a committee of six had been appointed to work in cooperation with a special draft board to be set up in the county for critical personnel needed by the Armed Forces. Members of the committee, all of whom are veterans of World War II, are Drs. Joseph M. Keating, Samuel C. Yachnin, Orlo H. Clerk of Passaic, and Francis R. Myers, Leopold E. Thron and David B. Levine of Paterson.

UNION COUNTY

E. M. Satulsky, M.D., Reporter

The opening meeting of the *Union County Medical Society* was held on September 20, at the Winfield Scott School in Elizabeth. DR. HERSCHEL S. MURPHY, the president, called the meeting to order at 8:30 p. m., and welcomed the members of the Woman's Auxiliary to the Union County Medical Society and members of the allied professional groups who had been invited to attend. A film entitled "Breast Self-Examination" was shown by the Union County Chapter of the New Jersey Division of the American Cancer Society.

DR. HERBERT M. ILL, trustee of the Widows and Orphans Society discussed the insurance plan for doctors and invited more of the members to become participants in this worthy endeavor.

Upon recommendation of the membership committee, DR. JOSEPH P. GADOMSKI, of Linden, was elected to full membership.

Dr. Murphy then introduced DR. JOSEPH I. ECHIKSON, past-president of the Academy of Medicine of Northern New Jersey and past president of the Essex County Medical Society, who spoke on *The Doctor's Obligation As a Citizen.* A very interesting discussion followed Dr. Echikson's brilliant paper.

The annual outing of the *Union County Medical Society* was a huge success. It was held on Wednesday, October 11, 1950, at the Colonia Country Club, Colonia.

Under the chairmanship of DR. W. M. GOLDEN, of Rahway, an interesting program of events was planned and the members who attended spent a most enjoyable day. Many of the politicians of the county were invited and introduced to the 150 members and guests who were present for a delicious steak dinner.

The society wishes to express its thanks to the many friends who contributed numerous valuable door prizes. The planned entertainment was excellent and enjoyed to the utmost.

At the end of the festivities, it was generally agreed that this outing was probably the most enjoyable that the society has planned in recent years and that the spirit of enthusiasm and comradeship that prevailed was the highlight of the day.

NEW JERSEY ORTHOPAEDIC SOCIETY

Philip Willner, M.D., Secretary

The fifth annual meeting of the *New Jersey Orthopaedic Society* was held at St. Francis Hospital in Trenton, New Jersey, on October 12, 1950.

The following scientific program was arranged by the Program Committee, Dr. Paul Finegan, Chairman:

1. Conservative Treatment of Trochanteric Fractures—A. M. RECHTMAN, M.D.
2. Complications in Surgery of Hip Fractures—O. R. CARLANDER, M.D.
3. Arthropathies—W. R. PETERSON, M.D.
4. The Combined Operation in Disc Surgery—W. SCHEURMAN, M.D. (by invitation).
5. Problems of Pathologic Fractures—OTTO LEHMAN, M.D.
6. Interesting Bone Tumors—A. S. THURM, M.D.

The following officers were elected at this meeting for the coming year: NICHOLAS S. RANSOHOFF, M.D., President; RAPHAEL R. GOLDENBERG, M.D., President-Elect; PHILIP WILLNER, M.D., Secretary; ROY R. CICCONE, M.D., Treasurer.

WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey met at the Medical Society Executive Offices, Trenton, on October 9, 1950, with Mrs. R. John Cottone, president, presiding.

The morning session consisted of reports from the county auxiliaries, showing that particular attention is being given to legislation, the 1-10-20 Plan, public relations and rural health.

During luncheon at the Carteret Club, Mrs. David B. Allman, immediate past-president of the National Auxiliary introduced the guest of honor, Mrs. Arthur A. Herrold of Shreveport, La., the current National president. Mrs. Herrold called attention to the Mid-winter White House Conference to be held December 3-7 and emphasized the immediate emergencies of the Auxiliary—to participate in the educational campaign, and to participate in the Non-partisan Committee work in the state. She mentioned that the subject of the National High School Debate this year is a "positive" for us, *Resolved That the American People Reject the Welfare State.* Mrs. Herrold concluded her interesting and informative talk with an over-all picture of Auxiliary conditions throughout the country.

At the afternoon session, Dr. D. Leo Haggerty of Mercer County, spoke on the work of the Non-partisan Committee in New Jersey.

AUXILIARY REPORTS

Bergen County
Mrs. Winton Johnson,
Chairman, Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held as a Membership Tea on September 19, 1950, at the home of Mrs. Floyd Keir in Englewood. Mrs. Asher Yaguda, of Newark, past-president of the State Auxiliary, and presently the state treasurer, was the guest speaker. She praised the Bergen County group for their efforts with the Rh-negative Blood Donor Club. The Rh-negative Club was initiated by the maternal welfare committee of the Bergen County Medical Society and fostered by the efforts of the Auxiliary. It has made available a file of volunteer donors of the rare Rh-negative blood. Mrs. Yaguda explained the workings of two state-wide projects, the Council for School Health Services and the Rural Health Program.

Fifty members attended the tea and 11 persons joined the Auxiliary. Mrs. Edward Sexton of Teaneck presided. Mrs. George Hoffman and Mrs. Luke Mulligan of Leonia helped with refreshments. The new members include: Mrs. Edward Grueninger, Mrs. John Williams, Mrs. Joseph Bono of Cliffside Park; Mrs. J. A. Lewin of Tenafly; Mrs. Henry Maddren, Mrs. Henry Metz of Hackensack; Mrs. H. M. Katzin of West Englewood; Mrs. Frederick Marx of River Edge; Mrs. John Jenkins of Maywood; and Mrs. Charles Abbott of Englewood.

Camden County
Mrs. Walter A. Crist
Chairman, Press and Publicity

The *Woman's Auxiliary to the Camden County Medical Society* was the hostess group for a Tri-County meeting October 3, 1950, at the Haddon Fortnightly, Haddonfield, in which Burlington and Gloucester County Auxiliaries participated. A covered dish luncheon preceded the meeting. Mrs. R. John Cottone, state president, was introduced as guest of honor by the county president, Mrs. Thomas H. McGlade. Mrs. Glen Eyre Wood, noted humorous monologist was the speaker. Mrs. Herman E. Wiant, chairman, Arts and Hobbies; Mrs. William Braun, chairman, and Mrs. Gordon F. West, co-chairman, Hospitality, were responsible for a delightful meeting.

Mrs. Leland Stetser, chairman, and Mrs. Vincent McDermott, co-chairman, Charity Fund, announced completed plans for a Card Party, Monday, October 30, 1950, at 1:30 p. m., at the Haddon Fortnightly for the benefit of the Nurse Scholarship Fund.

Cape May County
Mrs. J. S. D. Eisenhower, Jr., President

The *Cape May County Auxiliary* has been busy this summer. An Executive Board meeting was held in July at the home of the president for the purpose of discussing plans for the winter meetings. At this meeting it was revealed that one of

our members had taken the general chairmanship of a clam bake to be held in August at the County Park, the proceeds to go to the Burdette Tomlin Hospital, soon to be opened in Cape May Court House. Plans were discussed for a cake table (one of nine tables) at this clam bake, to be run by our Auxiliary. The cake table cleared $490 and was staffed completely by Auxiliary members working in shifts between 1:00 p. m. and 8:00 p. m. The entire clam bake itself cleared about $6000. We commend Mrs. George Brooks on this brilliant achievement.

We cooperated with The Medical Society in obtaining a list of physicians registered in our county since 1945.

We also, as interested voters, obtained a list of physicians and pharmacists not registered as voters, for the Non Partisan Committee.

We have endeavored, by personal interview, to obtain time on radio stations in Atlantic City for the purpose of putting on material sent from National Education Campaign headquarters but so far have been unsuccessful. The stations believe the subject too controversial.

Our 1-10-20 Plan chairman is cooperating fully in following up letters sent from the state level to the D.A.R., Granges, and Federated Women's Clubs urging them to pass a resolution opposing compulsory health insurance.

A letter to all members and eligible members in the county was sent out this summer by the president endeavoring to stimulate more active interest in the Auxiliary. This letter was accompanied by the president's annual report.

On the third Tuesday in September we held our first fall get-together which was a luncheon. We were happy to have as our guests, Mrs. Cottone and Mrs. McGlade and appreciate their traveling so far to visit with us.

Essex County

Mrs. Stuart Z. Hawkes
Chairman, Press and Publicity

The first Board meeting of the fall season was held at the home of Mrs. Pascal Baiocchi, first vice-president, in Newark. Following a pleasant tea, the meeting was called to order by our president, Mrs. Jesse T. Glazier. Among the committee reports we were particularly interested in hearing that of Mrs. Charles Minnefor of South Orange. During the summer months, Mrs. Minnefor organized a volunteer unit at the Newark City Hospital. There, under the auspices of the Essex County Blood Bank, Auxiliary members interview relatives and friends of patients who have received blood, and ask for blood donations. The Auxiliary serves during visiting hour four afternoons a week. Plans have been completed for our annual dance and also for our fall luncheon and meeting. At the latter we are anticipating greeting Mrs. Cottone, Mrs. McGlade and Mrs. Rauschenbach.

Passaic County

Mrs. Joseph E. Mott, Reporter

The *Woman's Auxiliary to the Passaic County Medical Society* held the first meeting of the season following luncheon at Gene Boyle's Restaurant, in Clifton, October 16, 1950. Mrs. T. K. Graham, presiding.

Dr. Joseph E. Mott, State Public Relations Committee chairman and Mr. James E. Bryan, executive officer of The Medical Society of New Jersey, the guest speakers, were introduced by Mrs. Paul E. Rauschenbach, Program chairman.

Dr. Mott discussed the five point plan of the Public Relations Committee of The Medical Society of New Jersey and gave an enlightening talk on its value. He spoke of health education, 'round-the-clock emergency service, county and state press conferences, health councils and the speakers bureau.

Mr. Bryan spoke briefly on the invaluable aid the Auxiliary renders to The Medical Society of New Jersey and remarked on the large attendance at the meeting.

Mrs. A. M. Schultz, chairman of the Nurses' Scholarship Fund told of the good reports of the four nurses being sponsored by the Auxiliary.

BOOK REVIEWS

S. Weir Mitchell: Novelist and Physician. By Ernest Earnest. Pp. 279. University of Pennsylvania Press, 1950. ($3.50)

Back in 1930 I was a resident in neurology at the Philadelphia Orthopedic Hospital. It was a quaint old-fashioned institution haunted by the memory of a genial and potent ghost; the ghost of S. Weir Mitchell. For all hospital activities, the base of reference was: what would Dr. Mitchell have thought? S. Weir Mitchell died in 1914, but having lived vigorously for 85 years, his memory had easily accumulated enough momentum to remain influential in 1930. And for all I know, his voice still echoes through the proud corridors of Philadelphia medicine.

S. Weir Mitchell was a pioneer in the understanding and treatment of nerve injuries, in the recognition of the role of the contralateral cortex in muscle movements, one of the first to recognize shell shock (during our Civil War), the founder of the country's first outpatient dispensary for neuropsychiatric cases (at the Orthopedic Hospital, of course), one of the first to grasp the physiology of the cerebellum, a foreshadower of modern psychosomatics, the deviser of the "rest cure", the discoverer of erythyromelalgia, (which to this day is still called Weir Mitchell's disease), the spiritual father of the now famous neuropsychiatric department at Blockley, the man who discovered Noguchi and set him on his path, the reviver of *Index*

Medicus, and the doctor who converted the alienist into the psychiatrist and who made it possible for a respectable person to be treated for mental illness. He also figures as an American minor poet of serious dimensions, and the author of a dozen best selling novels.

Ernest Earnest has told his story with charm and insight. He has painted in the few flaws that made Dr. Mitchell human and given depth to the qualities that made him great. He has sketched in the background of Philadelphia professional and cultural life from the 1830s to the 1900s. He has written a book which will absorb all doctors interested in neurology and psychiatry and all who have memories of medical school days in Philadelphia.

HENRY A. DAVIDSON, M.D.

The Pathology of Internal Diseases. William Boyd, M.D. Philadelphia, Lea and Febiger, 1950, 5th edition. Pp. 886. ($11.00)

In this the fifth edition of the *Pathology of Internal Diseases* Dr. Boyd has not only rewritten such subjects as hepatitis, cirrhosis, Cushing's syndrome, multiple myeloma, etc., but has also included entirely new chapters on such conditions as diffuse collagen diseases, congenital hemolytic disease, folic acid deficiency anemia and many others. This revision of an outstanding work has brought the book remarkably up to date with regard to significant recent advances in pathology and medicine in general.

The illustrations and color plates are well chosen and clearly explained in the text. This is one of those rare books which should be on the shelf of every practitioner of medicine. Dr. Boyd deals not only with pathology of internal diseases but correlates it with anatomy, histology and physiology. The modern concepts of mechanisms of diseases are emphasized and clearly presented. A unique feature of particular value to the internist is the discussion of the relation of symptoms to lesions which follows the account of each subject of major importance.

The style of presentation is free and refreshing, making for easy reading, comprehension and assimilation of the subject matter.

S. RAINONE, M.D.

Handwriting Analysis. By Ulrich Sonnemann, Ph.D. Grune and Stratton, New York, 1950. Pp. 276 with 257 illustrations. ($5.00).

For some reason, graphology has never, in America, enjoyed the status it has in Europe as a psychodiagnostic tool. One reason, I suspect, is that in this country we yearn only for such diagnostic instruments as are capable of being used on the basis of one sign equalling one finding. The American clinician's passion for liver function tests, trunk-thigh signs, x-ray films, et cetera is one evidence of this. Another is the popularity of tables or boxed charts of differential diagnosis where a series of discrete individual signs can be woven together to spell out a finished diagnosis. If the graphologist could say that a long downstroke always means this trait, and an undotted *i* means another, handwriting analysis would long ago have become popular here.

Unfortunately graphology cannot be learned that cheaply. Handwriting is a form of individual expression. All children are taught more or less the same school copy. After adolescence, each person modifies the school copy because of a complex of psychomotor habits rooted in his own individual personality. Reading back from the handwriting to the personality is no easy task. Sonnemann has given us a handbook which will assist the psychiatrist in interpreting handwriting. It will, however, do no more than *help* him. The book is not like a laboratory diagnostic table. The clinician cannot match specific graphologic findings against a list in the book and come up with a diagnosis. If a doctor finds a high basal metabolic rate, he can obtain a list of the six or ten diseases which whip up the metabolism and thus narrow his diagnostic problem. But if his patient offers a script sample where the downstrokes are firmer than the upstrokes, he cannot turn to this—or any other—book and find a neat list of indicated personality traits. The book has to be studied (not simply read, but sweated over), and the clinician has to fit a myriad of little findings into an over-all pattern before he can make any genuine interpretation of the handwriting sample. For the doctor willing to take the time and trouble to do that, this book will prove a useful manual.

WILLIAM S. SCHRAM, M.D.

Proctology in General Practice. By J. Peerman Nesselrod, M.D. Pp. 276 with 64 figures. Philadelphia, W. B. Saunders Co., 1950. ($6.00)

In this book, the general practitioner has a ready reference guide to diagnosis and treatment. However, the author assumes that the general practitioner has laid some preliminary foundation for quick identification of ano-rectal complaints and findings. Treatment, as outlined, meets with the highest standards of recognized authorities. Personal experience of the author richly enhances the teachings in these pages. Because of its concise format, the general practitioner can easily recognize the value of a proctologic examination.

Of particular value are the sections on routine examination and the usual anal conditions, always stressing the importance of ruling out malignancy. The author's opinion of the injection treatment of hemorrhoids should be an enlightenment to an alert practitioner. His view that injection therapy is limited in its scope by the etiology of the disease is well taken. The general practitioner can do well to be guided by this book.

For the student, intern, resident and specialist the book is a ready text which offers anatomy, physiology, pathology, symptomatology, diagnosis and treatment.

This publication deserves a place in every practitioner's library.

A. L. REICH, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **November, 1950** **No. 11**

FATE has challenged physicians in a peculiar way with respect to primary cancer of the lung. Of all internal cancers, those originating in the lung should be the most readily discovered while still locally confined. Not only can the lesions be found but they can be properly labeled. Excision of the cancer-bearing lung has been shown to be feasible, relatively safe and effective. Physicians, therefore, have the tools with which to find, label, and successfully treat cancer in this location.

SILENT PHASE OF CANCER OF THE LUNG

Cure of cancer of the lung was never seriously considered prior to 1933, when total excision of the lung was shown to be possible. During subsequent years, correlated studies of symptoms, roentgenographic shadows, bronchoscopic observations, cellular elements of sputum and surgically detected pathologic conditions have been made. Much is now known as to the life history, direction of spread and variabilities of the several histologic types of cancer of the lung. Sufficient time has elapsed to find from the literature a mounting list of recorded five year cures. It has been shown that cure rates are high if the patients submit to pneumonectomy at a time when there is no demonstrable growth outside the lung. Those patients who were saved by pneumonectomy have been able to enjoy life and have taken a productive position in society

Since cancers are growths, all extensive lesions were at one time small and localized. To eliminate all delay in the discovery of any cancer is, of course, essential. The average patient waits three months after the onset of symptoms before seeking advice. The record then shows that, by the orthodox methods physicians use to sort out patients with cancer of the lung from those with other conditions, there is another seven months' delay.

Why has the time schedule been so prolonged? There are four principal reasons:

1. The first and only symptom is usually nothing more than cough.

2. The stethoscope is unreliable because abnormal physical signs are either nonexistent or the same as those encountered with any common chest ailment.

3. Secondary infection is frequent during the symptoms phase and becomes a "red herring" leading to misdiagnosis and misdirected treatment, usually for recurring colds, chronic bronchitis, or virus pneumonia.

4. Abnormal areas of density in the conventional roentgenogram of the chest are extremely variable because of bronchial occlusion of the segmental or subsegmental bronchi. The anatomic arrangement of the pulmonary segments permits a wide range of possible shadows, depending on the relative position and superimposition of the aerated to unaerated segments.

Since the orthodox method of case finding depends on a lesion extensive enough to produce symptoms, and since the signs are so variable and confusing, it is obvious that delays in definitive treatment are bound to occur. The same situation developed in regard to case findings in tuberculosis. By depending on a warning symptom, visits to the physician, therapeutic trials and eventually the true diagnosis, the disease in about 85 per cent of all persons with tuberculosis had progressed to advanced stages. Case finding of the presymptomatic or silent lesion by the mass survey method has reversed the ratio of minimal to advanced cases, and a yield of 85 per cent of minimal cases are discovered.

Detectability of Cancer of the Lung

Cancer of the lung has a silent phase and is detectable. The air within the expanded lung provides a natural contrast medium for the detection of changes in density. Small tumors growing in the periphery will cast a direct shadow. Smaller

tumors centrally located cause a subsegmental or segmental bronchial obstruction, which will cast a shadow off the corresponding atelectatic segment. An airless segment will cast a shadow many times the size of the shadow of the tumor itself; thus there is actual magnification of centrally placed lesions which represent the great majority of all pulmonary cancer. This is fortunate, as small tumors within the pulmonary hilus might otherwise escape detection because of the growing of normal bronchial and vascular shadows in this area.

The case-finding program in tuberculosis is already performing a double service as the incidental finding of silent cancer has shown. Patients with suspicious abnormal areas of density apparent in a survey film have been observed; on exploratory operation these densities sometimes prove to be cancer. Although the discovery of cancer in tuberculosis survey programs has not produced startling figures, the follow-up of all suspect cases has been incomplete.

The Length of the Silent Phase

Rates of cancer growth vary, but there are isolated instances in which abnormal shadows existed for several years and yet on surgical exploration the lesion was found to be apparently localized. Exploratory operations also have been known to reveal extensive metastases. This in no way mitigates the value of screening unless recent roentgenograms were normal. If the survey roentgenogram represents the first and only roentgenogram the patient ever had taken, who will deny that, if the person had been having annual examinations previously, cancer in an operable stage probably could have been discovered. It is impossible to say how often patients should be screened in order to give reasonable protection from cancer of the lung. As further experience develops, this point can be determined. For the present, selective screening on an annual basis would seem to be wise. The highest yield will be among men over 45 years of age.

Need for Proper Labeling

Screening the whole population and spotting abnormal pulmonary densities is the first step. Prompt and adequate investigation of suspects is equally important. Additional information can be obtained by: positional, stereoscopic, tomographic roentgenologic studies, cytologic examination of sputum, bronchoscopy, and exploratory thoracotomy. Negative sputum or negative bronchoscopic examination does not prove the nonexistence of cancer. If the abnormal roentgenologic density cannot be explained with reasonable certainty on any other basis, surgical exploration should be advised. Fortunately, today this can be done with safety. With the chest open and the lung under direct inspection and palpation, the lesion which caused the abnormal shadow can be readily located. Lesions near the surface and many in the hilar area can be directly biopsied. If the lesion is located centrally, within a segment or subsegment, and direct biopsy is considered not to be technically easy, then the segment or subsegment bearing the mass should be removed. The best cancer operation, here as elsewhere, is one which follows the principle of the widest possible excision of the cancer-bearing organ with all the regional lymphatic vessels.

Conclusions

(a) Orthodox methods of case finding based on symptoms have produced a low yield of localized pulmonary cancers. (b) A silent phase of cancer of the lung exists and is detectable by periodic radiologic screening. Survey methods developed for tuberculosis case-finding may do a double service. The highest yield of silent cancer will be found in the male population of 45 years and over. (c) The labeling of survey-found abnormalities must be prompt and exact. Although time lags in tuberculosis follow-up may not prove to be fatal, time lags may cost patients their lives if cancer occurs. (d) Surgical exploration in cases in which cancer is suspected will establish the exact diagnosis and will permit immediate excisional therapy, which for most will be curative.

Silent Phase of Cancer of the Lung, Richard H. Overholt, M.D., and Ivan C. Schmidt, M.D., J.A.M.A., Nov. 19, 1949.

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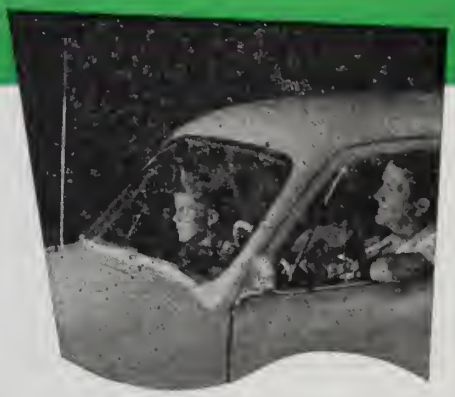

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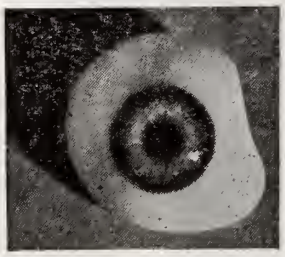

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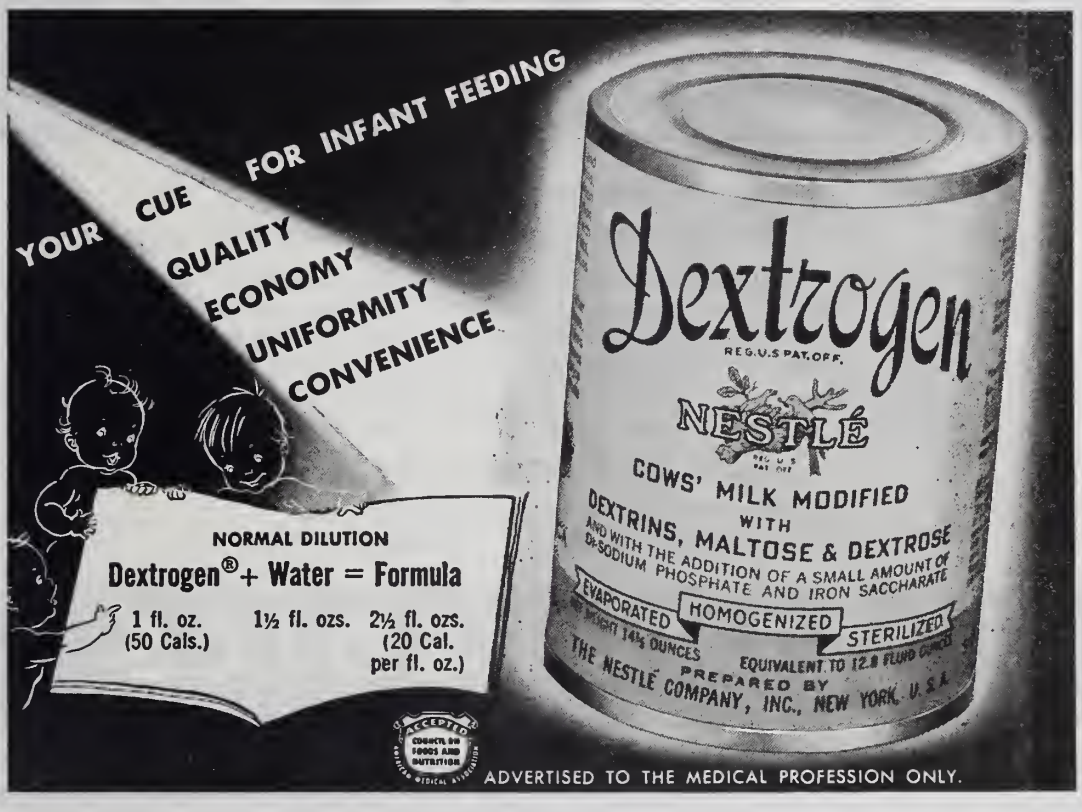

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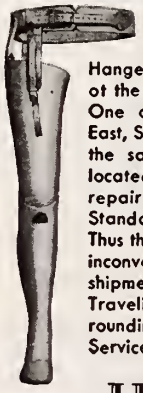

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

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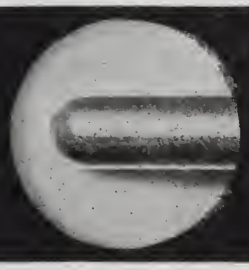

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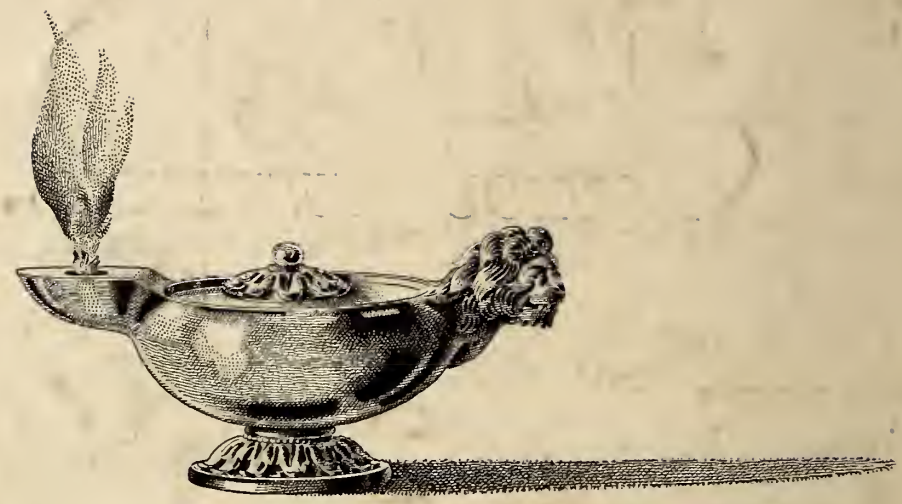

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CONTENTS—Pages 545 to 588

EDITORIALS— Page

PRESIDENT'S MESSAGE: ALLIES OF MEDICINE 545

TOMORROW'S MEDICAL PRACTICE 546

A FEDERAL ACADEMY OF MEDICINE 547

ORIGINAL ARTICLES—

INTESTINAL OBSTRUCTION IN MECKEL'S DIVERTICULUM—Max Danzis, M.D., Newark, N. J. 548

CATION EXCHANGE RESINS IN THE CONTROL OF CARDIAC EDEMA—Henry C. Crossfield, M.D., East Orange, N. J. 554

THE KARTAGENER SYNDROME—Samuel Cohen, M.D., Joseph D. Goldstein, M.D., and John Hamill, M.D., Jersey City, N. J. 557

SOME SURGICAL LESIONS OF THE STOMACH—I. S. Ravdin, M.D., Philadelphia, Pa. 561

THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES—Emil Frankel, Trenton, N. J. 565

STATE ACTIVITIES— Page

Dermatology-Syphilology Prize 553

New Cancer Journal 560

Malaria in Veterans 564

Directory of Services to the Handicapped.... 567

Trustees' Meeting 568

Dr. Allman Retires from Private Practice.... 568

Allergy Lectures 568

With New Jersey Medical Authors 569

Ophthalmologic Conference 570

Supplementary List of Members No. 8..... 571

OBITUARIES 571

COUNTY SOCIETY REPORTS 572

WOMAN'S AUXILIARY 576

BOOK REVIEWS 567, 577, 586

ANNUAL INDEX 1950 578

TUBERCULOSIS ABSTRACTS 587

Roster of Officers and Committee Chairmen, Advertising Page 3A

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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1. "A Study of Enriched Cereal in Child Feeding" Urboch, C.; Mack, P. B., and Stakes, Jr., J: Pediatrics 1:70, 1948.

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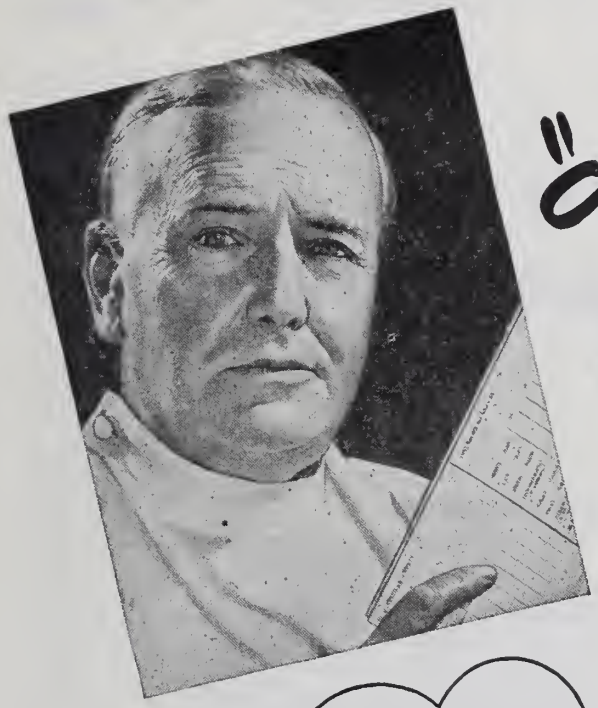

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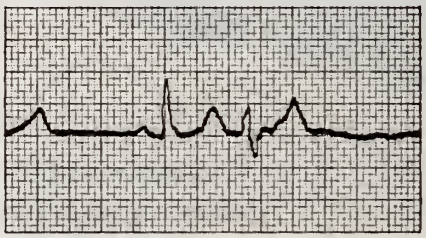
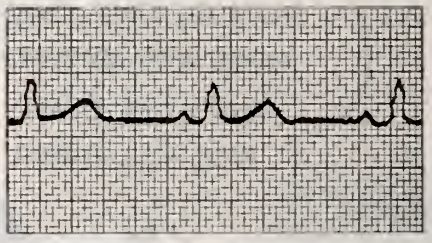
a significant advance in the treatment of ventricular arrhythmias . . . .

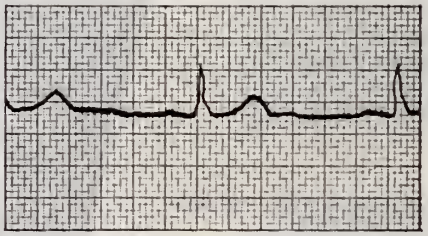
Effect of a single oral dose of PRONESTYL in ventricular premature contractions



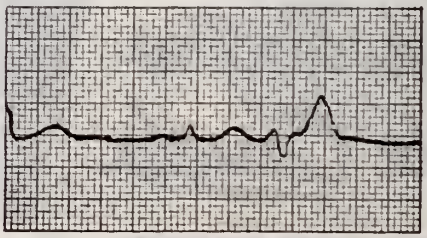
Lead II. Control tracing: normal sinus rhythm, ventricular extrasystole.



Lead II. Tracing 30 minutes after 1 Gm. Pronestyl orally. No ventricular premature contractions present.



Lead II. Tracing 7½ hours later shows persistent effect.



Lead II. Tracing 24 hours later shows return of ventricular premature contractions.

....PRONESTYL *Hydrochloride*

less toxic than quinidine

Indications and Dosage

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

Orally: 1 Gm. (4 capsules) followed by 0.5-1.0 Gm. (2 to 4 capsules) every four to six hours as indicated.

Intravenously: 200-1000 mg. (2 to 10 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. *If marked hypotension occurs, rate of injection should be slowed or stopped.*

For the treatment of runs of ventricular extrasystoles:

Orally: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

Intravenously: 100-500 mg. (1 to 5 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

Supply

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

PRONESTYL *Hydrochloride*

SQUIBB PROCAINE AMIDE HYDROCHLORIDE

"PRONESTYL" IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB

A urinary tract infection

resistant to *"...all available antibiotics and chemotherapeutic agents..."*[1]

TREATED WITH TERRAMYCIN

M. F., male, age 48

P. H.: Pyelonephritis of 1½ years' duration following ureterocutaneous implants (mixed infection); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Lab. data: Urinary cultures positive for P. vulgaris, E. coli, Staph. albus and enterococci.

Therapy: Terramycin 2 Gm. daily for five days; orally in divided doses q. 6 h.

Result: Urine cultures negative except for P. vulgaris by 2nd day of treatment. Response described as "good".

Case report abstracted from: King, E. Q. et al.: J.A.M.A. 143:1 (May 6) 1950.

CRYSTALLINE

Terra

suggested for:

acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.

NEW *Council-accepted broad-spectrum antibiotic orally effective—well tolerated*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

1. Terramycin may be highly effective even when other antibiotics fail.[1]
2. Terramycin may be well tolerated even when other antibiotics are not.[2]

mycin

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Dosage: On the basis of findings obtained at over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, *bottles of 16 and 100;*
100 mg. capsules, *bottles of 25 and 100;*
50 mg. capsules, *bottles of 25 and 100.*

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. *143*:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomow, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.

Pfizer

Antibiotic Division

CHAS. PFIZER & CO., INC., *Brooklyn 6, N.Y.*

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Spa Therapy . . .

The place is The Saratoga Spa

Have you a patient who needs

CARBON DIOXIDE BATHS

Many observations have been made on the changes which occur in the alveolar carbon dioxide tension, the skin temperature, and the respiratory metabolism of human subjects who have been submerged in baths of either carbon dioxide water or plain water.

The alveolar carbon dioxide tension showed a 5 to 10 per cent rise during baths in the carbon dioxide water, and returned to the resting level about twenty minutes after the bath. There was no significant change during baths in plain water.

There was no essential difference in the skin temperature during the carbon dioxide and plain water baths.

There was a marked increase in the elimination of carbon dioxide in the expired air during the time the patient was in the mineral water bath. This increase did not occur in the plain water bath.

No evident variation in the oxygen consumption occurred with either bath.

The possible source of the excess carbon dioxide is discussed. The evidence supports the theory that this extra carbon dioxide is obtained by absorption of the carbon dioxide in the water through the skin and its subsequent elimination through the lungs.

It is, therefore, concluded that the results obtained in the treatment of patients with carbon dioxide mineral water baths depend, in part, at least, on the absorption of carbon dioxide through the skin and its subsequent influence on the circulation and nervous system which occurs in the process of its natural elimination by way of the blood stream and the lungs.

As printed in American Heart Journal, Vol. 29, No. 1, Pages 44-61, January, 1945.

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3 weeks at The Saratoga Spa will benefit, refresh, relax your patients with such chronic conditions as Heart and Digestive disorders, Arthritis and related ailments, and Hypertension. At your request, we will send list of local, private practicing physicians who will cooperate with you as to treatment, rest and diet. Address Medical Director, The Saratoga Spa, 159 Saratoga Springs, N.Y.

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The Empire State's Contribution to the Medical Profession

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While reducing immediate morbidity and mortality, early diagnosis of venous thrombosis and prompt anticoagulant therapy also protect against femoral vein destruction for ". . . the instantaneous action of heparin nearly always puts an end to upward spreading of the process,"[1] with its later sequelae of valvular incompetence, venous stasis, pain, chronic edema and ulceration. Effective and readily controllable anticoagulant therapy is available with these Upjohn preparations:

Heparin Sodium, Sterile Solution
Depo-Heparin Sodium, Sterile Solution*

**Trademark, Reg. U. S. Pat. Off.*

1. Bauer, G.: Angiology 1: 161-169 (Apr.) 1950.

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Medicine... Produced with care... Designed for health

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- The container we furnish for used diapers sprinkles its soiled contents with an efficient antiseptic solution whenever the container lid is opened and closed.
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- A modern tested diaper supply service for our customer's exclusive use.

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- **INDIVIDUAL**
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for infant feeding

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1000% richer in *natural* Vitamin C than average orange juice

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In PHYTOTONE Vitamin C is provided in its complete and natural form as derived from natural plant sources... fruits and herbs which also provide natural Rutin, Vitamin K, Niacin and other factors of the Vitamin B Complex, as well as Pectin. High concentration of natural Vitamin C (120 mg. per fl. oz.) makes PHYTOTONE unusually efficacious as an infant feeding supplement. Its complete stability over long periods makes it unusually reliable. Routine use in early months of life helps avoid the greater tendency of very young infants to become allergic if orange juice is added to the diet too early.

PHYTOTONE is compatible with any infant formula... does not cause curdling of the milk. It may be added to the formula or to whole milk, fruit juices, or cereals. Recommended intake is 2 teaspoons per day until one year of age and then 1 tablespoon daily.

OTHER INDICATIONS: PHYTOTONE is also indicated to prevent or correct Vitamin C deficiency at any age, and as an adjunct to other indicated measures in debilitated or convalescent patients.

Adult dosage is one tablespoon before each meal and before retiring.

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ENGLEWOOD, NEW JERSEY

Sample and literature on request

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and NUTRIENT TONIC .....
TESTED ..... ACCEPTED .....

ELIXIR
Palaplex Ferrated

containing

IRON .. VITAMIN B_{12} .. FOLIC ACID .. LIVER .. and VITAMIN B COMPLEX with RICE BRAN EXTRACT

A truly delicious and flavorful preparation that assures patient acceptance and cooperation.

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Each 30 cc of PALAPLEX FERRATED contains:

Thiamine Chloride B_1	15 mg.
Riboflavin B_2	6 mg.
Pyridoxine B_6	1.5 mg.
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Folic Acid	1 mg.
Liver Extract 1:20	3 grs.
Ferric & Ammonium Citrate	15 grs.
Nicotinamide	75 mg.
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Alcohol Content 9 to 11 per cent by volume
In a delicious Sherry Wine—Rice Bran Base.

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THE ENTIRE ALKALOIDS
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OF
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(DAVIES, ROSE)

0.15 GRAM (APPROX. 2½ GRAINS)

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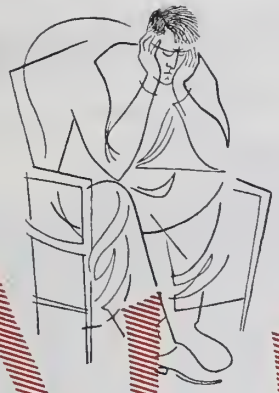
Prostigmin® methylsulfate

brand of neostigmine methylsulfate **'Roche'**

AUREOMYCIN

HYDROCHLORIDE CRYSTALLINE

in Brucellosis



The chronic ill health and mortality associated with undulant fever, caused by one of the strains of brucellae organisms, has been a serious medico-social and economic problem in this country. The treatment of these infections in man can now be satisfactorily carried out with aureomycin.

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Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, *Klebsiella pneumoniae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis, puerperal infections, Q fever, rickettsialpox, Rocky Mountain spotted fever, surgical infections, subacute bacterial endocarditis resistant to penicillin, tick-bite fever (African), trachoma, tularemia and typhus.

Capsules:
Bottles of 25 and 100, 50 mg. each capsule.
Bottles of 16 and 100, 250 mg. each capsule.

Ophthalmic:
Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

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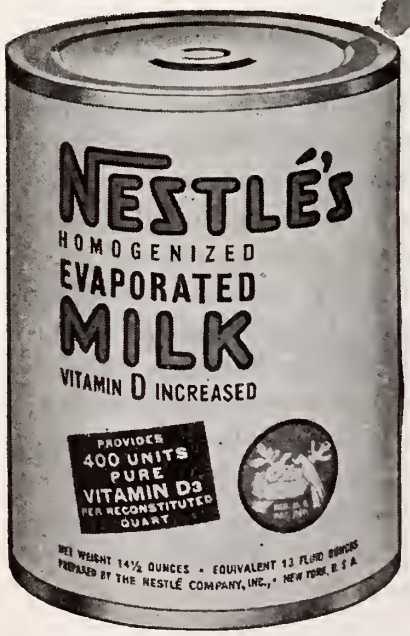
Our inspectors examine every single ten-gallon can of fresh milk as it comes from the dairy, but this is only the beginning of the tests we apply to Nestlé's Evaporated Milk.



From herd inspection to examination of the filled cans, careful controls at every step of production assure you that Nestlé's milk is of good quality, uniform in composition, safe for even the tiniest baby.

Antirachitic protection is assured by the addition of 400 U.S.P. units of genuine vitamin D_3 to each pint of Nestlé's milk—the first evaporated milk so fortified.

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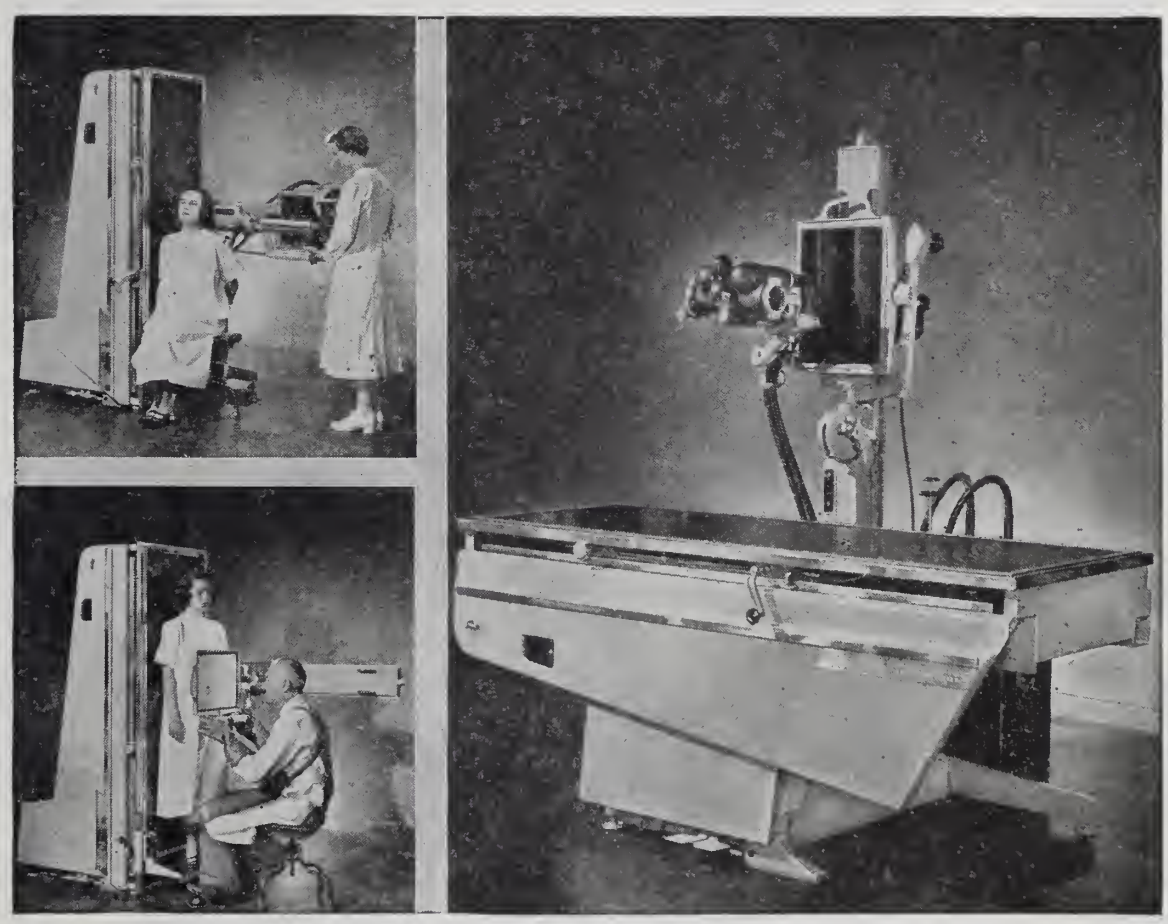
NOW... a single-tube Maxicon combination unit with table-mounted tube stand



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For PROMPT SEDATION when the oral route is not feasible...

0.2 Gm. 0.12 Gm. 60 mg. 30 mg.

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a long and distinguished career in urography.

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An 18 year history of dependable roentgenograms obtained without harm to the patient distinguishes the career of NEO-IOPAX as a diagnostic urographic agent. Since 1932, *hundreds of thousands of doses of* NEO-IOPAX have been injected with virtual freedom from serious untoward reactions. No other urographic contrast medium has equalled the safety record of NEO-IOPAX. No agent, experience with which is limited to a relatively small number of patients, can be deemed to be as safe. Because the patient's life and welfare take precedence over all other considerations in diagnostic investigation of the urinary tract, urologists and roentgenologists will continue to rely—as always—on NEO-IOPAX.

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NEO-IOPAX

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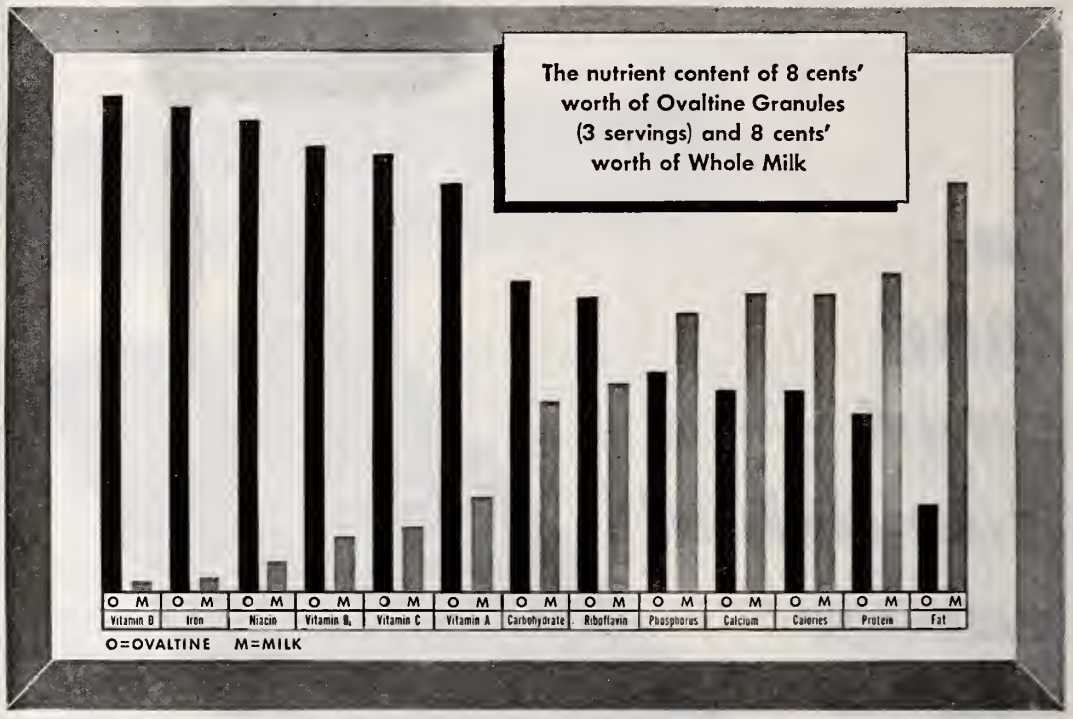

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Thiamine	0.90 mg.	0.16 mg.
Ascorbic acid	30 mg.	4 mg.
Vitamin A	2025 I.U.	625 I.U.
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** 8 cents' worth of milk

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Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

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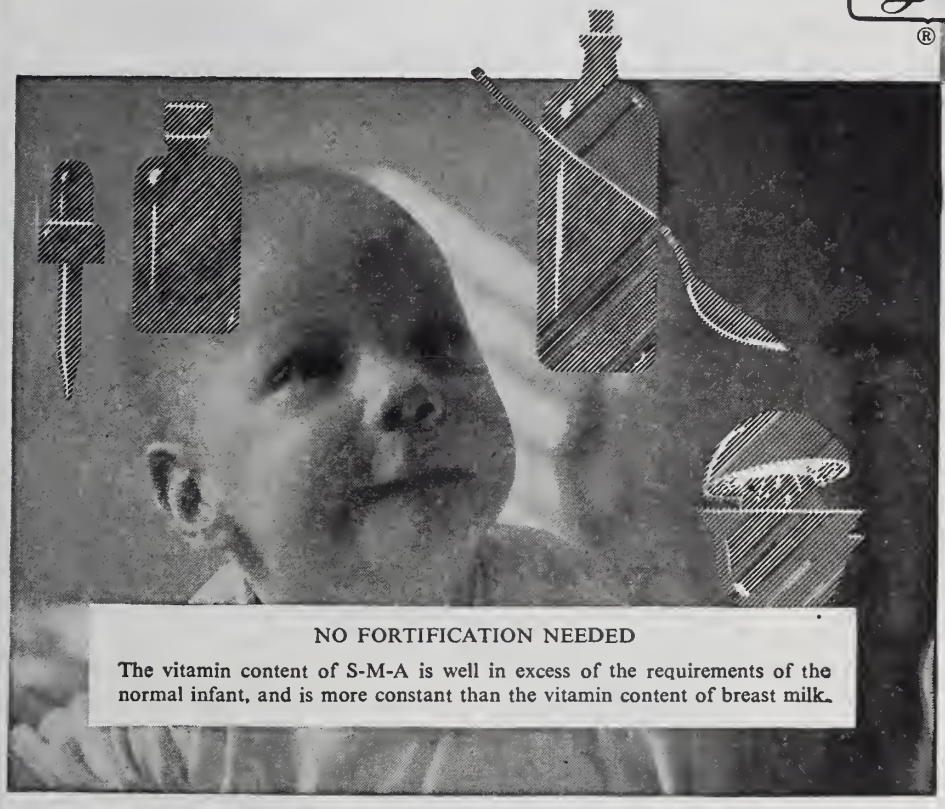

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No infant food is more like breast milk than S-M-A—in content of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

S-M-A CONCENTRATED LIQUID—cans of 13 fl. oz.
S-M-A POWDER—1 lb. cans

S-M-A, diluted and ready to feed, provides in each quart the following proportions of the minimum daily requirements for infants.

VITAMIN A 5,000 U.S.P. units	333%
VITAMIN D 800 U.S.P. units	200%
THIAMINE 0.67 mg.	250%
RIBOFLAVIN 1 mg.	200%
VITAMIN C 50 mg.	500%
NIACINAMIDE 5 mg.	—

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S-M-A®

vitamin C added
builds husky babies

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ALITRON

CAPSULE

FORMULA:

Liver Fraction Secondary	1:25	7 grs.
Ferrous Gluconate		3 grs.
Vitamin B_1		2 mgs.
Vitamin B_2		2 mgs.
Calcium Pantothenate		1 mg.
Nacinamide		10 mg.
Folic Acid		0.5 mg.

DOSAGE: 1 or 2 Capsules T.I.D.

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FORMULA:

Thiamin Chloride	4 mg.
Riboflavin	3 mg.
Niacin	30 mg.
Pyridoxine	1 mg.
Iron Gluconate	6 grs.
Liver Concentrate	1.5 gm.
Benzoic Acid	.03 gm.
Citric Acid	.02 gm.
Sherry Wine Vehicle	

DOSAGE: 1 or 2 Teaspoonfuls T.I.D.

A COMPLETE FORMULA FOR SECONDARY HYPOCHROMIC ANEMIAS.

A FINE TONIC FOR IRON AND VITAMIN B DEFICIENCIES.

AVAILABLE ON PRESCRIPTION AT NO EXTRA COST TO PATIENT.

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Anxieties vanish;
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Published Monthly Since 1904

Whole Number of Issues 556

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PRESIDENT'S MESSAGE: ALLIES OF MEDICINE

Any one who can read the newspapers now knows that congressmen who favored compulsory sickness insurance were coolly treated at the polls last month. In some states, commentators stated that the protests of the "medical and allied professions" were material in injecting a note of sanity into the campaign. In the midst of the general jubilation which attends this reprimand to the M-W-D supporters, we must not forget the truly significant role played by the "allied professions". Dentists, pharmacists, nurses and all others concerned with the healing arts did a top notch public relations job.

One of the quieter but most effective of our allies was the nurse. As I said in my message in September, the nurses are our old friends and allies. The sick patient craves the solace that the presence and ministrations of the doctor and nurse can bring. But with today's case loads, most doctors find that they simply cannot spend as much time with each patient as they would like. The hospital general duty nurse is at or near the bedside practically all the time. The special duty nurse devotes all her time to attending to a single patient. Some physicians take the nurse as much for granted as the furniture in the sick room. The truth is, however, that the nurse is a potent force for smooth recovery as well as a good right arm in carrying out the treatment program. From the very beginning of that profession, the nurse has been the physician's companion. She is with the doctor in the hospital, in the sick-room, and when needed in the battle-field area too. She has filled in the inevitable gaps in clinical care, so that bedside treatment becomes an uninterrupted continuum. She is the agent who transmits a written order into

clinical reality. Yet precisely because she does all these things with such silent efficiency, we often forget about the nurse as an individual practitioner of the healing arts. Month in and month out many nice things are said in medical journal editorials about many of our friends. But we seldom see any salute to the nurse. So let it be recorded here and now that we doctors do recognize the invaluable contribution of the trained nurse and appreciate the loyalty, devotion and self sacrifice that power it.

Aldrich C. Crowe, M.D.

TOMORROW'S MEDICAL PRACTICE

Even without a crystal ball, the alert practitioner today can forecast the shape of medical practice in the days when the class of 1950 meets for its tenth reunion. By that time prepayment medical care plans will have covered as much of the country as Blue Cross plans do today. But the spread of health insurance will have a far greater effect on the M.D.'s day-by-day routine than did the rising tide of hospital insurance.

In the first place, the doctor will have accustomed himself to far more lay intervention in medical procedures than is today considered possible. For when the bill-paying function passes from the patient to the "company", the latter is going to enforce its right to inspect records and to insist on advance authorization for expensive procedures. While there will be less of this under medical society plans than under commercial insurance, and less of it under voluntary than under compulsory projects, it is naive to suppose that even medical societies will be able to administer such projects without lay officials. The question "Was this treatment necessary?" or "Was this procedure authorized?" will be asked by the keeper of the purse, and the doctor will answer—or he won't be paid. This may be an undignified position for the practitioner, but it is an inescapable one. Experience shows that health insurance cannot function on the honor system. So the general practitioner, 1960, must be prepared to justify his procedures to a nonprofessional auditor.

A secondary result of this will be the invasion of much of the traditional privacy of medical records. You can't expect the "corporation" to pay you for treating syphilis unless you reveal the name of the patient and the evidence for the diagnosis. Not even a medical-society-sponsored plan is going to pay a doctor for six injections unless his bill indicates what the injections were.

A third result will be increasing importance to medical society membership. Whether the societies themselves sponsor the plans or whether commercial corporations or governmental agencies sit in the driver's seat, the fact will be that membership in a county medical society will become the simplest way of establishing status as a "reputable physician".

A fourth change, and probably a good one, will be in the direction of more meticulous record-keeping. The practitioner had better keep a copy of every report and bill he sends out, and of every certificate too. And there will be a plethora of "certificates" in the brave new medical world of tomorrow.

In all probability there will have to be some sort of standard nomenclature. Is one doctor's "traumatic encephalopathy" the same as another's "concussion syndrome"? Will "hyperthyroidism" be tallied in the same column as "exoph-

thalmic goiter"? The answer inevitably is a single, uniform medical terminology.

"Chronic gastritis" will be anathema, and "sacroiliac strain" perhaps as obsolete as "the vapors". Then will come a directive—all diagnoses must be supported by objective evidence. The company will not pay for the treatment of epilepsy until electroencephalogram confirms the diagnosis, and medication for nephritis can scarcely be authorized until the kidney function results have been filed. It will make for scientific accuracy, though it may be a bit hard on the practitioner who depends on his clinical hunches.

The doctor will grumble and gripe, but he will survive. Perhaps his clinical acumen will be sharpened by these more rigid standards. Or maybe not. At least he will get a month's leave every year (more than most of them get now) and he might spend it visiting the Nation's capital. Perhaps in the Smithsonian Institute there, along with the "Spirit of St. Louis" and an old horse-car, he may see the nostalgic outlines of a little black bag.

A FEDERAL ACADEMY OF MEDICINE

Pending in the Congress is bill H.R. 9156 which would establish a United State Medical Academy, somewhat analogous to West Point and Annapolis, for the training of physicians. The purpose of this proposal is two-fold. First, it would add one new medical school, thus increasing the number of physicians, and relieving the anticipated shortage of medical practitioners. Second it would keep a stream of young doctors funneling into the Army and Navy, and presumably into other federal agencies too. The arguments run something like this: what's the chief source of regular army officers? The government academy. What is the chief source of regular navy officers? A government academy. What should be our chief source of U. S. medical officers? Another government academy.

The analogy, however, is a poor one. There is no scope for the private practice of artillery officering, and no large-scale way of obtaining artillery officers except through special training schools. This is obviously not the situation with medical practice.

If the proposed medical school follows the lines of other federal academies, selection of students would be a matter of Congressional appointment. Uniform geographic spread around the country would be another prerequisite. Many medical student aptitude criteria have been proposed, but surely this is the most novel method yet suggested for determining who will make good doctors. Then too, one wonders by what means the alumnus could be compelled to enter the federal service. Once he has his M.D., what would happen if he passed a state board examination and decided to enter private practice? Would they court-martial him? (They could, if Congress subjected the medical students to military law—and this would be within its constitutional prerogative.)

If the Army and Navy supplies the internship hospitals, could the young alumnus get sufficient experience in pediatrics and gynecology? And could a federally owned and operated school possibly include in its program anything that deviated from official doctrine?

The suggestion is a thought-provoking one, but little details like the above would have to be thought through before any serious steps could be taken towards the establishment of a West Point of medicine.

INTESTINAL OBSTRUCTION IN MECKEL'S DIVERTICULUM

WITH REPORT OF A CASE WITH A LARGE ENTEROLITH *

MAX DANZIS, M.D., Newark, N. J.

During the years, 1944 to 1950, twelve cases of Meckel's diverticulum were found at operation at the Newark (N. J.) Beth Israel Hospital. Most of these findings were incidental to operations performed for other conditions not directly associated with this anomaly, such as appendicitis, ovarian cysts, postoperative adhesions, et cetera. These operations were performed by eight different surgeons. Six of the patients were males. It is generally considered that Meckel's diverticulum occurs twice as often in males as in females. In our series the ratio of males to females was one to one. Average age was 38. The youngest was one year old, and the oldest, 62. There were no deaths.

Included in this group is one case of intestinal obstruction in a male 38 years old. Obstruction was caused by a very large enterolith which evidently formed during a period of months or years in a large dilated Meckel's diverticulum, manifesting no symptoms until a short time previous to operation. This enterolith most likely extruded itself into the ileum, causing obstruction of that segment of bowel about 12 inches from the ileocecal junction.

In attempting to find a similar condition, we made a survey of 377 cases collected from the surgical literature between 1940 to 1948, but failed to find a single case of complete obstruction of the bowel by a large fecolith. We found only one author,[1] who reports a Meckel's diverticulum which contained several large, hard, bile stained concretions. He cites ten other cases with similar findings reported by other surgeons. These hard concretions were interpreted by previous writers at the time of operation, to be of gall bladder origin, but upon further analysis, they were found to consist of fecal material with bile pigment.

I shall not attempt to describe the embryologic, histologic and pathologic structure of this anomaly. This has been adequately reviewed in previous publications. The credit of giving the first description of this anomalous condition has ben attributed to several authors. Haber[2] quotes Lichtenstein, who said that Haldamus was the first to observe and describe this type of diverticulum in 1598. He also reports that Laveter cited a case in 1671, Ruysh in 1707 and Morgani in 1679. Haber[2] further says that Littre reported a diverticulum in a hernial sac in 1742. Schwei and Jackson[3] credit Littre having described it in 1700 and Ruysh in 1701. Regardless of these discrepancies, it is now generally recognized that the credit is due to Meckel, who gave the first adequate description of this condition, and an explanation of its embryologic origin, either in 1809, 1812 or 1815. The literature on Meckel's diverticulum has been very extensive during the last two decades. It is not the anomaly as such that engages the interest of the surgeon. It is the serious surgical complications that may develop as the result of the pathology associated with it.

LOCATION AND FREQUENCY

Meckel's diverticulum is usually located about three feet away from the ileocecal junction. However, the distance varies. Giant diverticula are rare, but there are some reports in the literature of their existence. The incidence of Meckel's diverticulum, based on postmortem findings, is usually given as 2 per cent. No reliable figures are available as to its frequency in the living. It is likely that its occurrence would be much higher than 2 per cent, if complete examination of the gastrointestinal tract were made at the time of every abdominal operation. A search for a Meckel's diverticulum is usually not made at the time of operation, unless some pre-operative symptoms point to such a possibility. Therefore, many of these symptomless diverticula are missed. Umphrey,[4] reports nine cases of Meckel's diverticulum in 3460 intra-abdominal operations, during a five year period. His incidence is thus about .03 per cent. He comments: "Since the incidence of Meckel's diverticula is approximately 2 per cent, there should have been 69 diverticula found in this series." Many of the diverticula present in these patients were not discovered at operation because of failure of a thorough abdominal exploration. One-third of these patients in whom the diverticula were found had had previous abdominal

* From the Surgical Service of the Newark Beth Israel Hospital.

surgical procedures. Evidently the presence of that structure was missed at the time of the first operation.

SYMPTOMS AND TYPE OF OBSTRUCTION

The symptoms of Meckel's diverticulum vary in accordance with the type of lesion found at the time of operation. If the diverticulum, having been dormant for many years, for some reason then becomes inflamed, it is usually associated with the symptoms common to all acute abdominal inflammatory conditions: pain, nausea and vomiting and abdominal tenderness associated with either localized or generalized muscle rigidity. If the inflammation becomes distinctly localized, there may be a palpable mass. However, this is not very common. Very frequently this anomaly causes obstruction of the bowel, because of torsion, volvulus, intussusception, or by bands and remnants of the ompholomesenteric ducts and vessels. Occasionally it may be found incarcerated in a hernial sac.

The most common complication of Meckel's diverticulum is obstruction. The clinical symptoms of obstruction vary, and are not as pronounced in the early stages as those of the inflammatory type. The pain is paroxysmal. There may be little early localized rigidity or tenderness. There are, however, nausea, vomiting and gradual doughy abdominal distention without definite localization in a single area. There is no demonstrable palpable mass. The obstruction may be brought about by a twist of the bowel in the region of the diverticulum, by constricting bands which interfere with the blood supply, or by chronic inflammation with narrowing of the ileum, or by an acute diverticulitis.[2] Intussusception by Meckel's diverticulum, particularly those associated with polyp formation, is also not an infrequent cause of intestinal obstruction. Dorling,[5] reports a case of intestinal obstruction which was caused by a double knot tied by a Meckel's diverticulum around the adjacent coil of small intestine, thus causing complete gangrene of the bowel. Resection and side-to-side anastomosis had to be done. Gastric heterotopic tissue in Meckel's diverticulum may be the cause of intrinsic intestinal obstruction. This obstruction is the result of the inflammatory reaction following ulceration in that area, with subsequent scar formation similar to that which occurs in duodenal ulcers. Obstruction of this sort is usually distinct from the other type of obstruction associated with Meckel's diverticulum. Aberrant pancreatic tissue in the diverticulum may also result in scarring, cicatrization and obstruction. Heterotopic tissue and ulcer formation, according to Haber,[2] occurs in about 25 per cent of cases of Meckel's diverticulum. Gastric heterotopic mucosa is much more common than pancreatic heterotopia. However, both may occur in one diverticulum. It is difficult to determine pre-operatively the presence of such heterotopic tissue in the diverticulum. Winkelstein[8] reports a case of an ulcer in Meckel's diverticulum which was diagnosed roentgenologically pre-operatively. This would indicate that thorough radiographic studies, particularly in cases associated with acute or recurrent intestinal hemorrhages, may be of great help in establishing the diagnosis.

INTESTINAL HEMORRHAGE

Intestinal hemorrhage is common in patients suffering from Meckel's diverticulum. It is the result of ulcer formation of the heterotopic tissue, and is most common in children. The hemorrhage may be massive and associated with symptoms of shock; or there may be recurrent episodes of bleeding. The differential diagnosis between hemorrhage due to heterotopic tissue, and the mild type of bleeding due to intussusception (frequently seen in children) is not difficult. Intussusception is usually associated with severe cramp-like pain, tenesmus, bloody stools, and the presence of a mass in that area; whereas in bleeding there is very little pain, hardly any tenesmus, and no palpable mass. Sibley,[6] uses the term of "Dyspepsia Meckeli" to designate a condition in which heterotopic gastric mucosa in a diverticulum secreting hydrochloric acid and pepsin, may act as an irritant to the ileum, causing spasm in its walls and the diverticulum, similar to the spasm associated with peptic ulcer.

OTHER COMPLICATIONS

Other complications may be associated with Meckel's diverticulum. Perforation may take place either as a result of ulcer formation, or by foreign bodies, such as fish bones, cabbage stalks or metallic substances, or by small enteroliths consisting of fecal concretions, which may closely resemble gall stones, but not large enough to cause obstruction. Various types of tumor tissue have been found in the diverticulum. Most are the result of aberrant elements. Other types of benign tumors have also been reported, such as adenomas, myomas, papillomas, enterogenous cysts and carcinoids. Malignant tumors are rather unusual[3] in Meckel's diverticula. Traumatic ruptures of a Meckel's diverticulum as a result of a blow on the abdomen have been reported. Abscess of the abdominal wall, and ileofistula may be formed secondary to this anomaly. Nonspecific regional enteritis involving Meckel's diverticulum, and perforated leiomyoma of Meckel's diverticulum have also been reported.[9]

A foreign body in a Meckel's diverticulum included in our series is described below:

A male child, age 7½ months, was admitted to the Newark Beth Israel Hospital on October 12, 1948, with a diagnosis of a foreign body in the intestine. The child had had no acute illness since birth, with the exception of an occasional cold. On August 31, 1948, the baby swallowed a whistle. He had a coughing spell at that time, but this subsided, and he had been in "perfect health" since. He had normal bowel movements after swallowing the whistle, and gained in weight. X-rays showed the whistle to be stationary in the small intestine. The child was admitted to the hospital for the removal of the foreign body. He was a well developed, well nourished alert child (lying comfortably in bed). X-rays showed a foreign body deposit in the right lower quadrant, without change of position. Film taken in the operating room immediately before the operation showed no change in the position of the previously reported foreign body in the intestinal tract.

Operation was performed on October 14, 1948 by Dr. A. B. Abrams. The abdomen was opened through a right rectus incision. A Meckel's diverticulum 6 centimeters in length was found. It contained a foreign body. The tip of the diverticulum was incised, and the foreign body was extracted. The base of the diverticulum was then ligated and removed between double clamps with scalpel, and the base phenolized. The stump was inverted and closed over with interrupted chromic sutures. The appendix was also removed. The child made an uneventful recovery. The report of the pathologist showed that the specimen consisted of a portion of intestinal tissue measuring 3½ centimeters in length, and 15 millimeters in diameter at the tip. The lumen at the tip contained a metallic foreign body one centimeter in length and one centimeter in diameter. The diagnosis was Meckel's diverticulum containing foreign body. There was a subacute inflammatory reaction in the wall of the diverticulum and a lymphoid hyperplasia of appendix.

INTESTINAL OBSTRUCTION CAUSED BY A LARGE ENTEROLITH

A male, age 38, was admitted to the hospital complaining of pain in the lower abdomen. He said he had been "perfectly well" until the night before, when he developed a sharp pain in the right lower abdomen, after supper. A hypodermic of morphine temporarily relieved this pain. The following morning the pain recurred, associated with nausea and vomiting. When I saw him, he did not appear to be very ill. He had a moderately distended abdomen, with no definite areas of rigidity or muscle spasm. He had slight tenderness over the right abdomen, and some rebound tenderness. There was no definite localization of pain and no palpable localized mass could be demonstrated. His entire abdomen was slightly tender and doughy. Temperature at home was 100.2. There was no upper abdominal rigidity and no obliteration of liver dullness. He gave no history of any gastro-intestinal disturbance at the time of examination. However, postoperatively, the following additional information was elicited which would have been helpful in making a definite pre-operative diagnosis. He stated that he had transitory paroxysmal pains during the past six weeks. The pain began in the epigastric region and lasted just a few minutes. There was no nausea and no vomiting during that period. For many months he had complained of gastric flatulence, and also of what he called a "griping" pain in his rectum during defecation. Blood studies made immediately upon admission showed leucocyte count of 8,950, polynuclears 79, lymphocytes 16, endothelials 1, eosinophiles 1, stab cells 3.

The patient was observed for about 4 hours, and during that time his pain beame slightly aggravated and the distention was gradually increasing. There was no vomiting. Differential diagnosis between acute appendicitis and intestinal obstruction was considered. In view of the sudden onset of pain, nausea and vomiting during the first day, and the absence of a history of a previous surgical operation, I thought first of appendicitis. However, in view of the absence of definite localized tenderness and rigidity, and only a moderately elevated rectal temperature (and in the absence of a high leucocyte count) the diagnosis of intestinal obstruction was also entertained. The low blood count in the presence of the acute clinical symptoms was of no diagnostic value in differentiating between an obstruction with or without an acute inflammatory process in the abdomen. An exploratory laparotomy was performed on the evening of admission. The abdomen was opened through a right rectus incision. There was a considerable amount of free fluid in the abdomen with marked

distention of many loops of ileum. The appendix and gall bladder were normal. A round, hard mass the size of a small peach was found in the ileum, about two feet away from the ileocecal junction. The mass could not be dislodged in either direction by digital manipulation. The loop of ileum proximal to the mass was much distended and deeply injected. About one foot proximal to the mass a diverticulum of the ileum was found. It had a very broad base, terminating into a short, sausage-like structure. Since it is unusual to find such a large, impacted fecal mass in the ileum, my first impression was that the obstructive mass was a large gall stone. This is not a rare cause of intestinal obstruction. The intestine was incised, and the mass enucleated. Upon section, it proved to be an inspissated fecal mass (enterolith), which, most likely, was formed in the broad base of the diverticulum, and lodged distally in the intestine. The incision in the intestine was closed over with a double layer of silk. The diverticulum was doubly ligated at its base and removed with scalpel and phenol and the base inverted. The abdomen was closed in layers with chronic catgut for peritoneum and fascia, and silk for skin. A million units of penicillin and 1 Gram of streptomycin were inserted in the peritoneal cavity. Postoperative diagnosis: Intestinal obstruction by enterolith formed in Meckel's diverticulum. The postoperative course was uneventful, and the patient was discharged about eight days postoperatively. The pathologist's report was Diverticulum Meckel's. Specimen received in two parts. The first part consists of a firm, friable, brown-green concretion composed of a fecal matter which measures 4 x 3½ x 2 centimeters. The second part consists of a formalin fixed fragment of tissue covered on one surface with wrinkled mucosa. It is irregular in shape, and measures 35 x 20 x 2 millimeters. There is an outpocketing from the mucosal surface which measures 10 x 8 millimeters, and the mouth of the outpocketing measures 5 millimeters. Sections through the diverticulum reveal it to be covered with mucosa and the wall is not thickened.

Diagnosis: Meckel's diverticulum containing mucosa of pyloric type. Chronic mucosal inflammation. Fecal concretion.

This case deserves particular consideration because of its rarity. Meckel's diverticulum is responsible for intestinal obstruction, either through adhesions formed between this anomaly and the abdominal wall, or by its attachment to the umbilicus, or by an acute inflammatory condition. Each of these types of obstruction is of extrinsic nature. However, the obstruction in this case is intrinsic. Obstruction of the intrinsic type is distinct from the extrinsic. The intrinsic type is usually caused by ulcer formation in heterotopic tissue and subsequent scarring, a condition similar to that prevailing in duodenal ulcer strictures; or it may be formed through aberrant pancreatic tissue, which is uncommon. Intrinsic obstruction by a large enterolith is very rare. There have been a few scattered reports of small enteroliths found with Meckel's diverticulum,

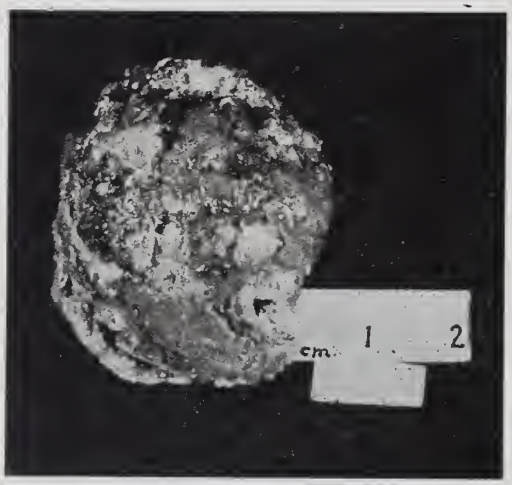

Figure 1. Fecal concretion.

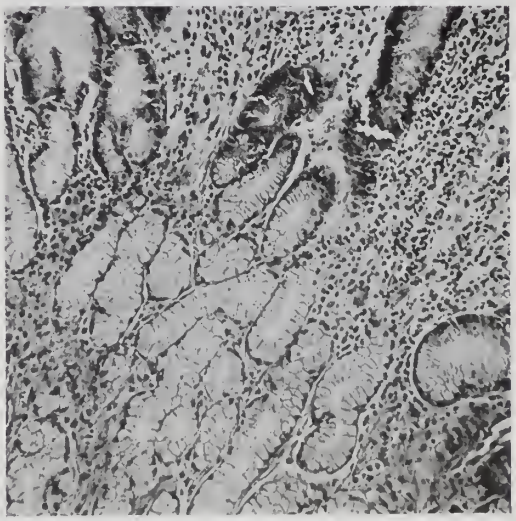

Figure 2. Mucosa of diverticulum showing an area of glands of pyloric type X 280.

which were suspected of being gall stones; but in none of these reports do we find an enterolith large enough to cause complete obstruction of the ileum.

I am including in this paper a summary of the ten additional cases of Meckel's diverticulum observed in our hospital between 1944 and 1950. In almost all of these cases the diagnosis of Meckel's diverticulum was an inci-

dental finding at the time of operation. Of these ten, three were admitted with a diagnosis of intestinal obstruction; three were called acute appendicitis; one patient was admitted with the diagnosis of alkalosis due to persistent vomiting as the only symptom. Two were admitted with the diagnosis of uterine or ovarian tumor. In one, the diagnosis of postoperative adhesions was made on admission.

DIAGNOSIS AT OPERATION

In only two of the ten cases was a perforated Meckel's diverticulum with peritonitis found

Figure 3. Baby R. M., foreign body in Meckel's Diverticulum

at operation. In the remaining eight cases, the diverticula were found three times in association with an acute or subacute appendicitis, twice in operations associated with an ovarian cyst and fibroid uterus. In one case the obstruction was definitely caused by a Meckel's diverticulum, and in two cases the condition was found in association with subacute intestinal obstruction due to postoperative adhesions. In only one case was a Meckel's diverticulum diagnosed pre-operatively, and that was the case of a metallic foreign body.

Six of these patients in whom the diverticula were found were previously operated upon for other conditions. In the first case, the patient had been operated upon three months previously for a gynecologic complaint. At re-operation, a ruptured gangrenous diverticulum was found, which had been missed at the first operation. The second was a young child upon whom an appendectomy had been done three weeks earlier. The child developed acute abdominal pain, nausea and vomiting three weeks *after* he was discharged from the hospital. He was re-admitted with a diagnosis of "acute abdominal condition", and at operation a gangrenous Meckel's diverticulum was found firmly adherent to the root of the mesentery, constricting a loop of small intestine. In the third case a cholecystectomy was done previously. At the second operation, Meckel's diverticulum was an incidental finding to a pelvic operation. This patient had a previous history of frequent paroxysmal abdominal pain, which might have suggested either appendicitis or diverticulitis as a possible cause. The fourth patient had, eight years before, been subjected to hysterectomy, left salpingectomy and left oophorectomy. She was admitted with a diagnosis of postoperative adhesions. She gave a history of mild abdominal pain off and on, but no symptoms of obstruction. Pain was paroxysmal in nature, which could have been explained as due either to appendicular colic or to diverticulitis. It is not likely that postoperative adhesions were the cause of the pain. Postoperative adhesions seldom give repeated attacks of colicky pain, unless associated with partial or complete obstruction. The fifth patient had an appendectomy one month prior to his present illness. Two days postoperatively, he developed some abdominal cramps, which subsided. The pains recurred after he was discharged from the hospital. On re-operation, a Meckel's diverticulum was found, causing intestinal obstruction. The sixth patient had had a hysterectomy six years previously. The operative record showed free fluid in the peritoneal cavity. Meckel's diverticulum causing obstruction of the small bowel was found. The paroxysmal pain and localization on the right side in the absence of the appendix, would

suggest an acute inflammatory condition. Meckel's diverticulum might have been considered.

DIAGNOSIS

The diagnosis of Meckel's diverticulum is almost impossible to make pre-operatively, even with the help of the x-ray. Usually, the symptoms are similar to acute appendicitis. This is particularly true in children. Since the frequency of this anomaly seems to be a little higher in the living than it was reported in post-mortem findings,[4] it is reasonable to suggest that a thorough exploration of the abdomen (particularly of the ileum) should be carried out in all operations where the symptoms are limited to the right side. This is especially true in all appendectomies, where the evidences of appendiceal disease are not sufficient to account for the pre-operative symptoms. Such a procedure would, in a certain ratio of cases, obviate the secondary operations consequent to complications of Meckel's diverticulum.

SUMMARY

1. The incidence of Meckel's diverticulum has not been definitely determined. Many diverticula are not discovered at operation because of a failure of thorough abdominal exploration.

2. The most common pathologic changes resulting from Meckel's diverticulum are obstructive and inflammatory.

3. The obstruction may be of extrinsic or intrinsic type. The former is more common.

4. Heterotopic tissue (such as gastric mucosa or aberrant pancreatic tissue) may cause intrinsic obstruction or intestinal hemorrhage. The latter is more frequent in children.

5. Perforations of Meckel's diverticulum due to ulcer formation or foreign bodies, may and do occur.

6. Tumor formation, due to aberrant elements or to adenomas, myomas, papillomas, et cetera, may be found associated with Meckel's diverticulum.

7. A rather unusual type of obstruction formed by a large fecolith or enterolith is reported. A survey of the literature failed to find a similar case. This should be borne in mind when operating for intestinal obstruction in the presence of a Meckel's diverticulum.

Thanks are due to Dr. M. Kannerstein, our pathologist, for the microphotographs, and to my surgical colleagues for permission to review their reports.

31 Lincoln Park

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DERMATOLOGY-SYPHILOLOGY PRIZE

The American Dermatological Association is offering a $300 prize for the best essay of original work, not previously published relative to some fundamental aspect of dermatology or syphilology.

Manuscripts typed in English with double spacing together with illustrations, charts and tables, are to be submitted in triplicate not later than February 1, 1951, and should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102 Second Avenue, Southwest, Rochester, Minnesota.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the three hundred dollar prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be the Diamond Jubilee Observance of its founding and will be held May 23-26, 1951, at Hot Springs, Virginia.

CATION EXCHANGE RESINS IN THE CONTROL OF CARDIAC EDEMA *

Henry C. Crossfield, M.D., East Orange, N. J.

It has been recognized for many years that the control of the sodium ion is essential for the proper control of water balance in the decompensated cardiac patient. Digitalis, ammonium chloride, mercurial diuretics and low sodium diets, have proved adequate for the average decompensated cardiac patient; however, in the severe case with a markedly diminished cardiac reserve, additional aids are needed. Unless these aids are made available, the patient's activity must be considerably curtailed, or the administration of mercurial diuretics becomes a frequent requirement. In the severe chronic decompensated cardiac patient, any additional procedure which will increase the excretion of sodium from the body is a welcome adjunct to the therapeutic regimen.

Sodium depletion in the body by means of mercurial diuretics is an effective procedure. We have, however, two objections to their frequent use: (1) the necessity of giving these diuretics by injection and, (2) the too rapid loss of sodium which causes nausea.

In 1935, Adams and Holmes[1] noted that insoluble formaldehyde resins of certain polyhydric phenols had a selective exchange capacity for cations. They found that hard water could be softened by passing it over various resins previously treated with sodium chloride. Phenolic and amino resins had the capacity to reduce total solids in tap water from 33 parts to one part per 100,000.

The trial of cation exchange resins for the purpose of withdrawing sodium from the body was first suggested by Dock.[2] Greenblatt and Gilwood[3] reported the use of a special ammonium cation exchange resin in three patients with one failure. Irwin *et al.*[4] had noted an increase in fecal sodium following the administration of a cation exchange resin of the sulfonic type to patients with congestive heart failure and cirrhosis of the liver. Diuresis resulted but potassium depletion and acidosis were complications.

Two cation exchange resins,[5] one a carboxylic type and the other a sulfonic type (one part calcium cycle, one part potassium cycle and two parts hydrogen cycle), have been available for clinical use in chronic cardiac decompensated cases.

Five patients with extreme chronic cardiac decompensation with cirrhosis and ascites were placed on the resins.[5] These patients had been followed for several years and every known method had been used for the control of their edema. They had been on digitalis, dicalcium phosphate, vitamin B complex, low sodium diet (approximately 800 milligrams of sodium), mercurial diuretics and ammonium chloride a part of each week. Most of them also received choline and liver. The amount and frequency of mercurial diuretics used were governed by the need to maintain adequate control of the edema. Dicalcium phosphate, ammonium chloride, low sodium diet and mercurials were continued after the resins[5] were started. It was observed that respiratory infections frequently caused a rapid weight increase in several of the patients.

Depletion of calcium, potassium and magnesium was anticipated as a result of previous reports that the resins increased the excretion of these elements along with the sodium in the stool. Perhaps the decalcium phosphate and the ammonium chloride supported the calcium and chlorides during the resin therapy because in no case did we note an appreciable drop. Clinical signs of too rapid loss of sodium were noted, but this must be expected if the level of sodium is to be kept low. This phenomenon occurred, for the most part, after an injection of a mercurial diuretic. One patient showed an apparent potassium depletion.

Four of the patients were treated successfully, and the fifth might have been had she been cooperative. A presentation of the cases, three in detail, will disclose some of the prob-

* Read by invitation to the Regional Meeting, American College of Physicians, Philadelphia, November 15, 1949.

1. Adams, B. A., and Holmes, E. L.: Transactions of the Society of Industrial Chemists, 54:1 (January 1935).
2. Dock, W.: Transactions of the Association of American Physicians, 59:282 (1946).
3. Greenblatt, I. S., and Gilwood, W. E.: Paper on the "Removal of Sodium *in vivo*" presented April 19, 1949, at the 113th Meeting of the American Chemical Society.
4. Irwin, L., Berger, E., Rosenberg, B., and Jackenthal, R.: Journal of Clinical Investigation, 28:1403 (November 1949).
5. The resins used in this project were kindly supplied by the National Drug Company of Philadelphia.

lems which were encountered and perhaps some benefits which may be derived from the use of a cation exchange resin of the carboxylic type in the management of severe chronic cardiac decompensation.

CASE ONE

A female, 60 years of age, with advanced rheumatic heart disease, had had rheumatic fever in her teens with several recurrences. Examination revealed a double mitral lesion, auricular fibrillation, and a "beef heart". The base of her lungs showed obliteration as the result of adhesions, and pleural thickening from rheumatic disease, recurrent pleurisy and chronic hydrothorax. She had cirrhosis of the liver with one-plus cephalin cholesterol and a troublesome ascites which had been treated since 1943. The left kidney presented a double pelvis and ureter; however, its function was fairly normal. Complications were a cardiospasm with some delay in emptying the esophagus, and a chronic colitis of many years' duration.

This patient had been getting from 8 to 20 cubic centimeters of mercurial diuretics intravenously each month since 1943. The carboxylic resin,[5] starting with 10 Grams before each meal and gradually increasing to 20 Grams before each meal, was added to her therapeutic regimen on April 9, 1949. While on the resins she received only one or two cubic centimeters of the mercurial diuretic each month except in two instances. During May, when she had a slight cold, she received 2 cubic centimeters for three injections, and in November, when she was given the sulfonic type resin[5] for several days, she required two injections of 2 cubic centimeters each of the mercurial. The sulfonic type resin[5] was not tolerated and proved ineffective. The weight curve and clinical observations indicate she was very well compensated by the use of the carboxylic type of resin. She enjoyed her food better during the time she was on the resin. On July 27, 1948, her urea nitrogen was 20.5 milligrams; chloride 400 and calcium 9.5 milligrams. On January 3, 1949, urea nitrogen was 25 milligrams, serum albumin 4, and serum globulin 2.2 milligrams. On April 9, 1949, her chlorides reached 450 milligrams. On October 24, 1949, urea nitrogen was 15 milligrams, calcium 10.3, and carbon dioxide was 68 volume per cent. This indicated an improvement in her blood chemistry while on the resin.

An electrocardiogram made prior to the resin therapy was similar to those found in advanced rheumatic heart disease with auricular fibrillation and ST depression. On November 25, 1949, a follow-up electrocardiogram was taken which showed a marked diminution in the voltage. Some of this was considered to be due to potassium depletion. As a result, one Gram of potassium salts was given three times daily to correct this suspected deficiency.

CASE TWO

A male, 72 years of age, gave a history of frequent attacks of grippe for many years. After each attack, he developed dependent ascites and shortness of breath. The heart had been irregular, off and on, for years. Since 1947, he has had a large heart with right bundle branch block and auricular fibrillation most of the time. On April 22, 1949, an electrocardiogram revealed auricular ventricular dissociation. He presented a large aortic arch with a calcifying plaque. This patient had a duodenal ulcer in 1944. In January 1949, he had a respiratory infection. He required 14 cubic centimeters of mercurial diuretics in March to reduce the edema which followed this cold. His weight for 12 months prior to resin therapy ranged between 179 and 194 pounds. There was a precipitous drop of the weight when he was on a rice diet and bed rest with daily intravenous mercurial injections for one week. Following this drop, the weight was reasonably well maintained with the carboxylic type resin[5] (10 to 20 Grams before meals) and without mercurial injections until he developed a cold in October 1949. He was then placed on the sulfonic type of resin[5] for several days with no effect. He developed an immediate hemorrhage from his duodenal ulcer with a drop in his red cell count to 3,600,000. The carboxylic type resin (10 Grams before meals) was resumed with benefit to his ulcer and with a subsequent drop in his weight. Blood chemistry studies on April 15, showed calcium 10.2 milligrams and chloride 240. On April 29, the chlorides were 270; June 2, 370; on August 23, 370; and on November 18, 320 milligrams, and the calcium was 10 milligrams. These determinations indicated no change in chloride or calcium values while on the resin.

CASE THREE

An elderly white female with chronic decompensation for years, since 1948, had been admitted to the hospital on four occasions for acute decompensation. She had been getting 2 cubic centimeters of mercurial diuretic three times a week before she was admitted on April 24, for pericardial effusion, anemia, acidosis and evidence of decompensation in the lungs, liver and extremities. She returned to the cardiac clinic on May 25, and was started on the cation exchange resin,[5] carboxylic type, 10 Grams before each meal. Her weight had varied between 136 and 155 pounds during the previous year.

She received only 2 cubic centimeters of mercurial diuretic per week from May 25, until November, except for an occasional week when it was omitted. Though the control of the weight was not completely satisfactory, she was able to get along on much less mercury than prior to the administration of the carboxylic type resin.

On April 25, the phenolsulphonthalein test showed only 35 per cent excretion of the dye in three hours. The urea nitrogen was 38 milligrams, and nonprotein nitrogen 66. This was reduced to normal limits during her hospital stay and was again normal on May 17. These returned to the previous high levels while the patient was taking the resin; however, this was probably due to the patient's dietary indiscretions at home. The calcium and chlorides were not altered.

CASE FOUR

A female, age 60 years, had a large dilatation of the aorta and marked arteriosclerotic disease. She took the carboxylic type resin[5] (10 Grams before meals) for two weeks with a drop in her weight from 112 to 106 pounds. She was then given the sulfonic type resin[5] and developed a dermatitis. This was probably allergic. The patient was hospitalized for two weeks and the dermatitis subsided. The carboxylic type resin was resumed with no bad effects, and the patient has been well maintained on this therapy.

CASE FIVE

A female, 62 years of age, had cirrhosis of the liver and chronic cardiac decompensation with ascites and edema for years from rheumatic disease. She was always uncooperative, and although a great deal of mercurial diuretics was given, she was not controlled. She was first placed on the sulfonic type resin[5] (10 Grams before meals), but she could not tolerate this treatment because of a "burning" sensation in the stomach and nausea. The carboxylic type resin[5] was then prescribed (10 Grams before each meal), and although she took this resin for only one month, she was better controlled during that time

When the sulfonic type resin[5] (one part calcium cycle, one part potassium cycle and two parts hydrogen cycle) was used, the patients rejected it because it was unpleasant to take, produced burning, nausea, and the results were not satisfactory. It could be dangerous in patients with inactive peptic ulcers because hemorrhage may occur, probably due to increase in gastric acidity.

The carboxylic type resin[5] was well tolerated by all patients, even in one in whom a peptic ulcer was reactivated by the sulfonic type resin. The dose best tolerated in this small series of patients, ranged between 10 and 20 Grams before each meal. Patients objected to taking more than 20 Grams at one dose.

Since the capacity of the carboxylic type of resin for the sodium ion apparently increased in an alkaline medium, antacids were given between meals. It has been estimated that the carboxylic type resin was capable of eliminating about 10 milligrams of sodium per dry Gram of resin. Theoretically, this represented between 100 to 600 milligrams of sodium removed per day in the feces of the patient.

Estimation of sodium in stools, urine and blood were not made in these patients for two reasons: (a) the difficulty in making such estimations and, (b) the clinical symptoms of sodium depletion are easily recognized. Poll and Stern[6] observed the symptoms of weakness, restlessness, mental confusion, apathy, and even coma and death following excessive diuresis. Klinghoffer[7] observed nausea, anorexia, muscle cramps and vascular collapse as side effects of marked sodium depletion. Our observations include weakness, which may be profound, a marked drop in blood pressure, loss of appetite, nausea and vomiting, and sometimes diarrhea. The diagnosis of excessive sodium loss is therefore easily made so that corrective therapy can be instituted.

The potassium deficiency is most easily determined by watching for development of small deflexions of the electrocardiograms with a more rapid cardiac rate. One of these patients required potassium to correct an apparently produced deficiency. There was no depletion of calcium or chlorides in these patients, probably because these elements were supplied as part of the routine medical management.

It is possible that some improvement in the present carboxylic type resins could be and will be made by modifying the slight phenolic odor and rendering it more palatable. However, in its present form, the carboxylic type resin was acceptable to the patients.

The sulfonic type resin (with one part calcium cycle, one part potassium cycle and two parts hydrogen cycle) was not acceptable to the patients, and the side effects produced by its administration were greater than any therapeutic effects.

The carboxylic type of resin, however, has a limited beneficial effect in the management of the patients with congestive heart failure if their sodium intake is 800 milligrams or less. The clinical evidence shows the carboxylic type resin permits as good a control of the patient's edema with a fewer number of injections of mercurial diuretics.

It should be emphasized that the use of the carboxylic resin does not permit unlimited sodium in the diet. A low sodium diet (less than 800 milligrams) is a necessary factor in obtaining satisfactory results with this resin.

6. Poll, D., and Stern, J.: Archives of Internal Medicine, 58:1087 (December 1936).
7. Klinghoffer, K. A.: International Clinics, 1:22 (March 1941).

144 Harrison Street

THE KARTAGENER SYNDROME*

SAMUEL COHEN, M.D.,[1] JOSEPH D. GOLDSTEIN, M.D.,[2] and JOHN HAMILL, M.D.,[3]
Jersey City, N. J.

The syndrome of sinusitis, bronchiectasis and complete transposition of the viscera is usually referred to as the "Kartagener triad". Kartagener[4] in 1933 reported four cases, illustrating these findings, although Siewert[5] almost 30 years earlier, had published the first case. Adams and Churchill[6] made the first English language contribution in 1937. In their review of the records from the Massachusetts General Hospital since 1886, 23 cases of situs inversus were diagnosed and among this group, five of these, amounting to 22 per cent also had other features of the triad. Russakoff and Katz[7] found that there were 50 cases recorded in the literature up to 1946.

The following case is reported because some interesting clinical observations were made over a span of 16 years leading up to an attempt at surgery for the bronchiectasis. The concepts of the pathogenesis of bronchiectasis in such instances are reviewed.

A white male, age 20, was admitted to the Pollak Hospital for Chest Diseases on September 16, 1949. He had lived with an uncle who had died of tuberculosis in 1939. His mother had had many episodes of vasomotor rhinitis and eczema.

The patient was first seen by one of us (J. G.) in 1934, at the age of four, with a history of bronchitis when two years old. After this he had had recurrent attacks of wheezing, dyspnea and productive cough. The nasal mucous membrane was pale and swollen, and a clear mucoid discharge was noted. Dextrocardia was present and wheezes were audible in both lungs. X-ray (Fig. 1) showed transposition of the viscera, and bronchovascular markings were increased in both lung fields. Three sputa examinations were negative for tubercle bacilli. Intradermal tests gave a marked reaction to apples, and moderate reactions to house dust, tomatoes, cucumbers, cinnamon, raisins, banana. Desensitization therapy was instituted. The child then had only an occasional mild asthmatic episode up to January 1941. Contact was then lost with the patient until 1947, when he reappeared with a history of more frequent attacks of dyspnea and wheezing. The positive findings at this time revealed injection of the conjunctivae, excessive nasal secretions, and signs of emphysema and asthma. Skin tests now gave positive reactions also to timothy and rag weed. The boy—now 17 years old—received another course of desensitization therapy, apparently with some benefit. In September 1948, he developed pain in the left chest with blood streaked sputum, and subsequently lost six pounds. A diagnosis of possible bronchiectasis and/or tuberculosis was considered.

A left sided appendectomy was performed in 1944. Chronic postnasal discharge had been present for many years.

The patient was first seen in the Chest Clinic as a "contact case" in 1934. The tuberculin test was negative then, and was not reported positive until 1946. X-ray in February 1948 revealed increased bronchovascular markings with some linear infiltration in both basal lung fields, in addition to the dextrocardia. A roentgenogram (Fig. 2) in March

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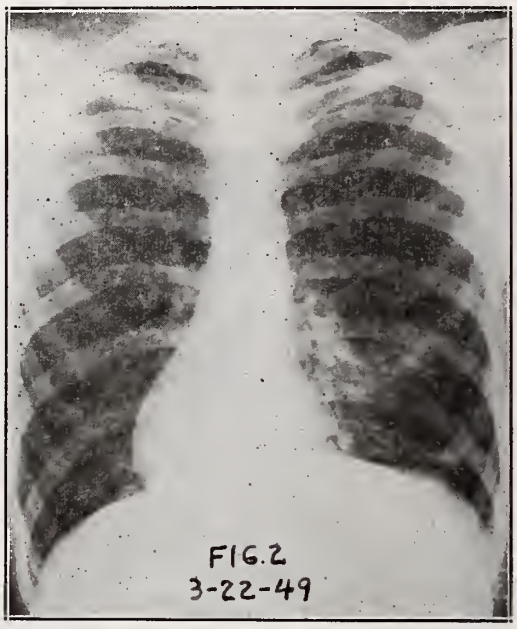
1. Chief, Medical Division II, and assistant to the medical director.
2. Consultant allergist.
3. Formerly resident physician, Division II.
4. Kartagener, M.: Beitrage zur Klinik der Tuberkulose. (Vienna), 83:489 (1933).
5. Siewert, A.: Cited by Adams and Churchill, see footnote 6.
6. Adams, R., and Churchill, E.: Journal of Thoracic Surgery, 7:206 (1937).
7. Russakoff, D. and Katz, M.: New England Journal of Medicine, 235:253 (1946).

1949, showed definite increased infiltration on the left.

Present Illness: He developed increased cough and non-foul expectoration in the latter part of August 1949, and subsequently some fever which precipitated his admission to the hospital.

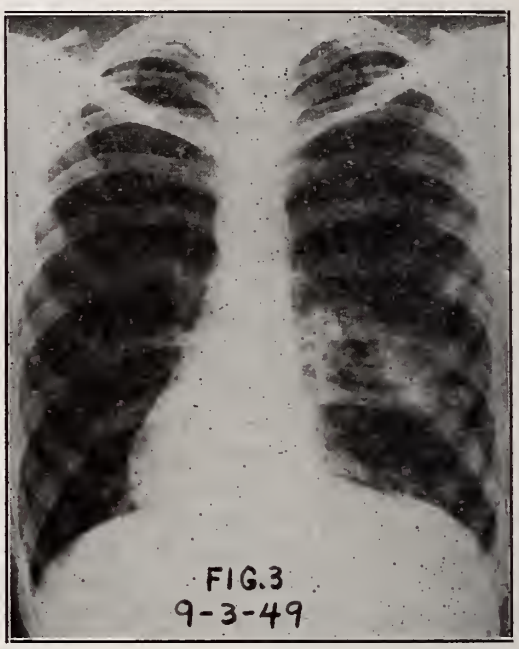


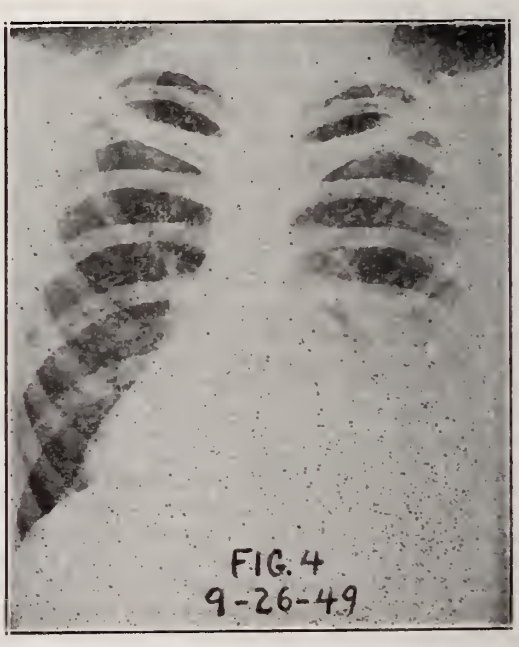
Status on Admission: He was not acutely ill, and temperature was normal. Considerable mucopurulent nasal discharge was present. Dextrocardia was noted and the heart sounds were regular. Rales were audible at both bases posteriorly, more on the left. The chest film of September 3, 1949, (Fig. 3) prior to admission, now revealed a bronchopneumonic process in addition, between the fourth to sixth left anterior ribs, with a radiolucent area containing a fluid level in the fifth anterior interspace.

Diagnoses on admission were: (1) situs inversus. The electrocardiogram was characteristic of dextrocardia; (2) bronchial asthma; (3) pulmonary tuberculosis or bronchiectasis with superimposed pneumonia.

Course: Repeated sputum examinations were negative for tubercle bacilli on smear and culture. On September 25, 1949, his temperature rose to 101.8, and he complained of sharp left sided pleuritic pain which persisted for several days together with increased cough, expectoration, and sustained fever. The left lower lung field was obscured by a rather homogeneous density. (Fig. 4) Satisfactory response was obtained with intramuscular penicillin and the roentgenogram of October 22, 1949, (Fig. 5) revealed considerable clearing. It was now apparent that we were dealing with a pneumonia and pleurisy superimposed on a probable bronchiectasis, rather than tuberculosis. He later had several asthmatic episodes and received relief with adrenalin and demeroi.

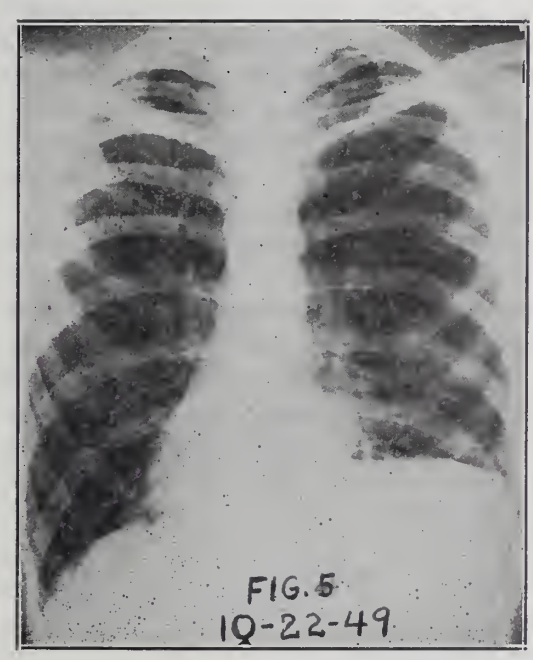
The patient signed his release on November 10, 1949, but returned later for bronchographic study of all five lobes. (Fig. 6) There was evidence of cylindrical bronchiectasis in portions of both lower lobes, and in the left middle lobe. Examination of the sinuses showed small frontal cells, poorly developed sphenoidal cells and considerable loss of aeration in the ethmoidal cells and antra.





Functional respiratory studies showed a marked reduction in the maximum breathing capacity to 45 liters (normal is 110 to 150) and the vital capacity was 2630, which is 62 per cent of normal, indicating very significant ventilatory impairment.

The patient re-entered the hospital for possible resection of the involved bronchiectatic areas. An exploratory thoracotomy was performed on February 16, 1950 by Dr. Herbert C. Maier, our consultant thoracic surgeon. The left lung was emphysematous and had three lobes, but the fissures were incomplete. Excision was not done for two reasons: (a) the inadequate anatomical cleavage increased the surgical hazard, and (b) a feeling that resection would aggravate the pulmonary emphysema and further depress pulmonary function and perhaps produce a respiratory cripple. The patient's postoperative course was uneventful, and he was discharged on March 6, 1950. At this time moderate postnasal discharge and cough with expectoration of one to two ounces of mucopurulent sputum daily was present.



COMMENT

In addition to the basic criteria of the Kartagener syndrome, this patient had associated bronchial asthma and emphysema which aggravated his respiratory difficulty. It is unlikely, however, that the asthma *per se* played a significant role in the development of bronchiectasis. Change of residence to a warm dry climate, judicious use of chemotherapy, postural drainage, and treatment for the sinusitis and asthma, were outlined to the patient as measures for symptomatic relief. However, it is interesting to note that for the continued cough and expectoration, the patient was subsequently given penicillin by the aerosol route to which he showed respiratory intolerance. This reaction to aerosol therapy is not uncommon in some asthmatics.

From a roentgenologic point of view, it is noteworthy to comment on the radiolucent shadow containing a fluid level as seen on the film of September 3, 1949. This led to a possible diagnosis, on admission, of tuberculosis with cavitation. However its rapid disappearance with penicillin therapy nullified this impression. The fluid-level shadow probably represented a pneumatocele, which is not an uncommon radiologic finding in pneumonia.

Situs inversus is rare. Its incidence per hundred thousand is given as 2 by Adams and Churchill,[6] as 9 by Gould[8] and as 10 per hundred thousand by Morse.[9] However, there is a high incidence of bronchiectasis in such cases, figures ranging according to various observers[6, 10, 11] from 16 to 23 per cent. While it is hard to see how the situs inversus or dextrocardia may predispose to or cause bronchiectasis, the simultaneous occurrence of the two conditions could be assumed[6] to co-exist as stigmata of maldevelopment. Kartagener[4] also considered the bronchiectasis as a congenital

8. Gould, D. M.: Journal of the American Medical Association, 127:753 (1945).
9. Morse, D. G.: Diseases of the Chest, 10:515 (1944).
10. Kartagener, M., and Horlacher, A.: Schweizerische Medizinische Wochenschrift. (Basal), 65:782 (1935).
11. Olsen, A. M.: American Review of Tuberculosis, 47:435 (1943).

anomaly. Olsen[11] in his analysis of 85 patients with dextrocardia observed that (besides those who showed evidence of bronchiectasis) there were eleven patients who had other congenital defects in addition, such as heart disease, hydrocephalus, cleft palate, et cetera. He believed that the bronchiectasis in the type of case under discussion was due to some congenital anomaly of the bronchial walls primarily, which made them more vulnerable to the factors of bronchial obstruction and infection. The finding, in our case, of an incomplete fissure in the left lung which had three lobes, raised the possibility of other congenital pulmonary aberrations—perhaps affecting the bronchi.

Attention is also called to the frequent association of congenital absence of the frontal or underdevelopment of the paranasal sinuses, and the usually concomitant infection as a potential source for descending infection of the bronchi. Benda and Huet[12] mentioned that the bronchiectasis may be due to repeated infections superimposed on congenitally abnormal bronchi. Churchill[13] has recently referred to two children whom he observed to have *situs inversus* and agenesis of the sinuses, who had no definite evidence of bronchiectasis. Both of the children, however, had profuse nasal discharge and expectoration by cough, of large amounts of mucous secretions. They had the benefit of climatic therapy and chemotherapy, and bronchiectasis was not yet apparent. In addition, he mentioned the case of a young man with a Kartagener syndrome whose mucoid secretions became purulent only after an attack of bronchitis at the age of 14. Churchill's belief[13] at present, is that the bronchiectasis of the "Kartagener triad", is a secondary manifestation, and that the basic abnormality may be an altered secretory activity of the mucosa of the respiratory tract. In this connection, Farber[14] has recently postulated that there may be a constitutional defect of secretions in various glands throughout the body in cases of so-called cystic fibrosis of the pancreas. The pulmonary lesions seen in such instances, particularly bronchiectasis, he believes,[14] may be caused by the thick inspissated tracheo-bronchial secretions which can produce atelectasis and infection. It is apparent from this discussion that while some intriguing concepts have been formulated, no definite final statement can now be made as to the pathogenesis of bronchiectasis in the Kartagener syndrome.

100 Clifton Place

NEW CANCER PERIODICAL

A new bulletin on cancer progress entitled "CA" has been published by the American Cancer Society under the auspices of the Cancer Society, the New Jersey Division, Inc., and The Medical Society of New Jersey. Now being distributed to the physicians of the state by the New Jersey Division, it will be published every two months.

First issue of the bulletin contains a discussion of new developments and several articles on breast cancer, one by Dr. Herbert Willy Meyer taking up the question of "Modes of Breast-Cancer Spread" and the manner in which they determine treatment and diagnosis.

Purpose of the bulletin is to condense, for physicians, authentic information about diagnosis, treatment control and research *before* the news reaches the general public. Each issue of "CA" will contain a feature or two written about a specific clinical aspect of cancer by an authority, a question-and-answer section based on queries most frequently made by doctors, a clinical-pathologic conference from some well-known institution, practical reports from the literature, up-to-the-minute cancer news and a calendar of pertinent meetings.

Subscriptions to the new bulletin are offered to physicians of New Jersey without cost. A request to the American Cancer Society, New Jersey Division, Inc., 9 Clinton Street, Newark 2, New Jersey, will be sufficient for placement on the mailing list.

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12. Benda, R., and Huet, P.: Bulletins et memoires de la Societe de medicine de Paris (Paris, France), 64:252 (1948).
13. Churchill, E. D.: Journal of Thoracic Surgery, 18:284 (1949).
14. Farber, S.: New England Journal of Medicine, 229:655 (1943).

SOME SURGICAL LESIONS OF THE STOMACH*

I. S. Ravdin, M.D., Philadelphia, Pa.

It is not possible in the time available to give a description of the many lesions of the stomach which from their inception, or following a variety of complications, become surgical. Some belong to the rare pathologic lesions which every surgeon may encounter a few times during a busy professional life. Others, however, are met frequently and account for a very high proportion of the deaths which occur each year in every community.

The most serious common surgical lesion of the stomach is cancer. And yet cancer of the stomach is a curable disease, just as is cancer of many other organs. The only known cure is a wide removal of contiguous attaching structures and, in addition, a radical resection of the stomach itself. Though this is being accomplished more frequently than it was a decade ago, the end-results in the best of our surgical clinics are not better than eight to ten per cent of three-year cures of the resected cases. We must, in view of past experience, ask ourselves why it is that at this period of development of the art and science of surgery, a patient with a gastric cancer has such a poor chance of living free from evidence of metastasis for three to five years? At this time the only hope of increasing the number of cures lies in the earlier diagnosis of the disease and an earlier and more thorough operation.

It is highly possible that the end results could be improved even without extending the operation were general practitioners, internists and surgeons to agree upon the possibility that any ulcer of the stomach seen by x-ray may already be malignant or that any benign ulcer may become malignant. After the careful study of the material available in our clinic, I am convinced that this can take place. A review of the literature further fortifies this opinion. But the opinion or even the conviction of a few men is not sufficient materially to change the outlook for the future. There must be a more widespread acceptance of the fact that cancer *can* occur in a benign gastric ulcer.

It is to me an inconsistency that we, as physicians, should accept the fact that chronic ulceration of numerous surfaces in other portions of the gastro-intestinal tract can become malignant while at the same time deny the possibility of such transformation in the stomach. This attitude is, I believe, associated with the fact that for years we have combined gastric and duodenal ulcers under the term "peptic ulcers", thereby suggesting that these lesions have a common primary etiology. Duodenal ulcer rarely, if ever, becomes malignant. It may, however, be associated with factors of secondard importance which, at this time, are not clearly understood because they have not been defined in relation to certain biologic characteristics which condition the development of malignancy at any site.

I have been deeply concerned by the frequency with which cancer of the stomach has been found at operation in patients who have had symptoms of gastric ulcer for several years and in whom, during this period, roentgen evidence of healing and recurrent ulceration has been repeatedly demonstrated. At operation spreading malignancy, from the ulcer site, is too frequently found. The importance of obtaining a more widespread unanimity of opinion on this matter should be immediately evident.

The diagnosis of early malignancy is most difficult. The diagnosis of late gastric malignancy is purely of academic interest as far as the patient and the surgeon are concerned. It is difficult, perhaps impossible, for even the most skillful roentgenologist to distinguish with assurity between a benign and a malignant gastric ulcer or to diagnose early superficial spreading gastric cancer. The size of the ulcer is of little help. The position of the ulcer is of only limited help except that ulcers of the greater curvature are generally considered maligant, unless proved otherwise. Even roentgen evidence of obliteration of the niche

* Read before The Medical Society of New Jersey at its Annual Meeting, May 24, 1950. This work is from the Surgical Clinic of the Hospital of the University of Pennsylvania, Philadelphia.

or crater may be due to filling of the ulcerated area by rapidly proliferating malignant cells.

Gastric acid curves may be no real help for a very considerable number of patients with proved gastric malignancy where free hydrochloric acid is present. And a number of patients with benign gastric ulcer have an anacidity. The nocturnal gastric secretion is often not diagnostic.

The study of the gastric potential may be helpful but it is not now diagnostic. The Huggins iodo-acetate and the Seibert tryptophane test are useful but not diagnostic. The earlier studies concerning the value of the cytologic examination of certain fluids and secretions as a means of diagnosing malignancy in some organs has now been extended to a study of esophageal and gastric secretions for a similar purpose. Malignant cells have certain features in common which assist in this complex diagnosis. Positive smears are diagnostic; negative ones are not. In the hands of a few highly trained investigators this method of diagnosis has become increasingly helpful, but in the hands of others (with less exacting technic and more limited experience) the results are not sufficiently accurate to be helpful.

Gastroscopy should be helpful, but I have seen so many instances where the true nature of the process was not disclosed by this procedure that I now place little reliance on it. Every surgeon knows that frequently with the abdomen open and the lesion in his hand the true nature of the disease is often not clear. Too frequently, when it is clear the lesion is either not resectable or not curable.

RESECTION OF THE STOMACH

The first resection for gastric cancer was performed by Jules Pean on April 5, 1879. The patient died a few days later. Two years later Billroth successfully resected a pyloric carcinoma, but the patient succumbed to metastasis four months later.

We must consider two types of resection; palliative and radical. Palliative resection is done because of demonstrable spread of the disease beyond the area of resectability. Radical resection implies the hope of cure. Palliative resections should be accomplished more frequently than they have been done in the past. The patient is more comfortable, and, I believe, will in general live longer, once the primary, major lesion is resected. If we will label these operations as palliative resections at the time of operation, we will formally acknowledge the limitations of the operative procedure.

The operation should in every instance be as extensive as it is possible to make it. The surrounding mesentery should always be widely resected. The transverse colon should be resected more frequently than has been done in the past especially when the lesion has become attached to the transverse colon or mesocolon. In all pyloric carcinomata, the duodenum should be resected for at least 2½ centimeters, for the malignant process frequently extends into the duodenum.

In every possible instance a radical gastric resection should be accomplished. Extensive operations must be done for relatively small tumors. A few clinics must cautiously extend the frequency of total gastrectomy. In some instances, a transthoracic operation will be preferable, but in many cases, a transabdominal total gastrectomy can be accomplished. The important thing is that the widest possible section be carried out with the hope that during the next decade the end results of the gastric cancer will have been improved.

GASTRIC HEMORRHAGE

Hemorrhage is the commonest of the major complications of ulcer. It occurs, however, in the duodenal ulcer more frequently than in the gastric ulcer. While indications for operation in *perforation* are clear, the indications for operation in the presence of *hemorrhage* are not always so clear.

In the Hospital of the University of Pennsylvania, where internists and surgeons have long been interested in this, the data have pointed strongly to the fact that (when all bleeding ulcers are considered) a controlled medical program has been associated with the lowest mortality. T. Grier Miller has found the mortality following the use of Meulengracht or similar diet to be 2 per cent in series of over 300 patients. The difficulty with many of the reported series treated by internists is

that they do not include the deaths which occur when (as the result of failure of a medical program) patients are transferred for operation following several days of exsanguinating hemorrhage during which time hypotension and anoxia have persisted. The surgical mortality under such circumstances approximates 100 per cent.

We are now following a plan which can be summarized as follows:

1. Every bleeding ulcer is seen jointly by an internist and a surgeon.
2. Operation is done as soon as it becomes evident that continuing hemorrhage places the life of the patient in jeopardy.
3. The older the patient, the greater is the likelihood of surgical therapy being necessary. The waiting period in these older patients is less than in the younger patients.
4. Whether the operation is done as an emergency, or after cessation of the bleeding and partial recovery from the anemia, the operation for a bleeding ulcer should, in my opinion, consist of a radical gastrectomy and, if at all possible, resection of the ulcer. Dependence must not be placed upon vagus resection. Gastro-enterostomy, with or without attempted external ligation of vessels around the site of the ulcer, is useless.

PERFORATION

The clearest indication for operation is the perforated ulcer. The duty of the doctor, following the diagnosis of perforation is clear; for the most important consideration is saving the life of the patient. If the history is a good one and if the physical signs are positive, the surgeon need not wait for the demonstration by roentgen ray study of air under the diaphragm. Exploratory laparotomy with simple suture of the perforation and reinforcement with omentum is at present the classical therapy. Gastric resection, although extensively used by some surgeons, in the presence even of a simple chemical peritonitis, is, I believe, not advisable.

PYLORIC OBSTRUCTION

Pyloric obstruction, from a gastric ulcer in the pylorus, is not uncommon. Frequently the obstruction is not due to cicatricial stenosis but is associated with spasm or edema or both. When the obstruction is the result of pyloric spasm it is relieved, in whole or in part, by the administration of spasmolytic agents. When due to edema, with or without coincidental spasm, the differential diagnosis, even with the aid of competent roentgenologic study, may be difficult. Low plasma protein suggests that the obstruction is due, at least in part, to edema. Under such circumstances, suction drainage, which puts the stomach at rest, and the administration of plasma or albumin infusion, will result, after a few days, in definite evidence of a functioning pylorus.

GASTRIC ULCER

The only operation which can be considered adequate for a gastric ulcer is a radical gastrectomy. Local excision, pyloric resection or gastro-enterostomy have, I believe, no place in the therapy of a lesion which, if not already malignant, may provide the fertile soil for subsequent neoplastic change. The decision should not rest on the opinion of the internist, the radiologist or the gastroscopist, nor even on the observation of the surgeon with the abdomen open and the lesion in his hand.

If these statements be true, and I am sure that they are, a radical resection remains the operation of choice. The experience of more than a decade is now sufficient to assure us that this operation is attended by a high incidence of cure, by a low incidence of recurrence of ulceration, either in the stomach or jejunum (4 per cent), and by a low mortality.

In the ulcers of the cardia the operation of choice is a transthoracic transdiaphragmatic gastric resection. We have in two instances done total gastrectomy for lesions that eventually proved to be benign ulcerations.

Whatever the approach and whatever the operation, the resection should be adequate. By this I mean that *not less than 70 per cent of the stomach should be resected.* It is as easy to do a major resection as a minor one, and it is no more difficult to do the anastomosis necessary for the restoration of gastro-intestinal continuity. One must at the operating table measure the extent of the proposed resection. It is often impossible to tell how much was resected by weighing the excised portion of the stomach.

NONCARCINOMATOUS STOMACH TUMORS

Lymphosarcomas of the stomach are in our experience uncommon tumors. Many of the reported cases undoubtedly are atypical carcinomas or plasmacytomas. They may be found as localized tumors or as diffuse infiltrating lesions resembling linitis plastica.

The leiomyosarcomas of the stomach may become very large lesions before the patient comes to operation. Their exact nature may not be diagnosed until the lesion is exposed at operation. I recently operated on a patient in whom we suspected a malignant myoma and, gratifyingly, found at operation a moderately large lipoma of the gastric wall. The muscle tumors, benign or malignant, are best treated by radical gastric resection.

Polypoid lesions of the stomach are reported to be rare, but we have found these more common than many of the supposedly more frequently occurring tumors. They may be found in any portion of the stomach, but over 90 per cent of those operated in our clinic have been found in the distal half. They may contain all of the tissues of the gastric wall or they may be true adenomatous polyps consisting of highly differentiated glandular cells. The polypoid lesions, benign or malignant, may give rise to obstruction or hemorrhage. It is important that one be sure that the lesion under consideration is benign before recourse is taken to a conservative operation. Unless a competent pathologist is available for accurate histologic diagnosis, gastric resection is the operation of choice. Even then, both the pathologist and the surgeon are chagrined when further study of carefully prepared sections discloses malignant changes in supposedly benign polypoid adenomatous lesions. Adenomatous polyps in any portion of the gastro-intestinal tract must be considered potential precursors of malignant lesions.

SUMMARY

1. What is frequently called the chronic gastric ulcer may in reality already be a malignant lesion. In our clinic, only about 75 per cent of the lesions are benign while nearly 25 per cent are malignant when the tissues removed at operation are carefully studied by a competent pathologist.

2. The pooling of gastric and duodenal ulcers under the general classification of "peptic ulcers" has retarded adequate therapy in many instances of potential or already developed gastric malignancy. The fact that a chronic duodenal ulcer never becomes carcinomatous has no relationship to the possible frequency with which a chronic gastric ulcer undergoes malignancy. Chronic gastric ulcer more commonly occurs later in life than the chronic duodenal ulcer, so that the age of the patient is of no help in determining the correct diagnosis.

3. If the general practitioner, the internist, and the surgeon will accept the fact that accurate diagnosis is often impossible; if they will further accept the fact that while duodenal ulcer is primarily a medical disease, gastric ulcer is primarily a surgical lesion, we will, in the future, find that resectability in gastric cancer will be improved and cures materially increased.

3400 Spruce Street

MALARIA IN YOUR VETERAN PATIENT

Veterans Administration regulations provide that a veteran making claim for a recurrence of malaria must submit medical evidence supported by a positive smear.

Accordingly, it is requested that any physician obtaining a positive smear in a veteran patient forward the prepared slide, with proper identification of the veteran including name, claim number, time and place of smear, and a brief statement of the clinical findings in a suitable container to the Adjudication Officer, Veterans Administration Regional Office, 20 Washington Place, Newark.

THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES

Emil Frankel, Trenton, N. J.
Director, Division of Statistics and Research, N. J. State Department of Institutions and Agencies

A milestone in society's efforts to improve the extremely serious situation with regard to the care of the mental patients in the United States was reached with the recent publication of *The Mental Health Programs of the Forty-Eight States* by The Council of State Governments. This is a report to the Governors' Conference which on the occasion of its forty-first annual meeting in June, 1949, passed a resolution recognizing that mental hygiene needs and the care and treatment of the mentally ill have created some of the most important social and financial problems confronting the states today and directed that a nationwide factual study of the existing activities and facilities be made.*

INSTITUTIONS AND AGENCIES

In New Jersey as in other states there is a growing demand for more effective mental health and hospital programs. This study is welcome therefore as a guide for future action. Sound programs must be based on answers to the questions: "What are the real needs?" "What can be done now to meet those needs adequately?"

Such a wealth of significant information has been brought together in this document of 377 pages that it is possible, in a brief article such as this, to refer only to a few of the most important ones.

OVERCROWDING

Overcrowding is the most extensive problem in state hospitals today. These state institutions account for the bulk of all care and treatment programs to the mentally ill. It is the states which receive the full impact of this shattering shortage of adequate facilities.

An indispensable element in any program for care for the mentally ill of any state is the provision of buildings in which that care is to be given. Various kinds of buildings are needed, some patients are young and many are old; some are strong and many are feeble; some are agreeable and tractable no matter how serious their disorder, others are extremely disturbed and difficult to work with.

Building programs should be undertaken by all states as soon as practicable in conformity with well-conceived master plans. Such plans should provide fireproof and fire-resistant buildings for patient care and treatment; separate facilities for patients who need differential care and treatment; necessary occupational and recreational facilities; and adequate housing for those employees who must live on the grounds. Construction programs should adhere to the highest standards of sanitation with respect to kitchen and dining room facilities, water supply, sewage disposal, and general housekeeping.

CARE AND TREATMENT

Apart from preventive activities, the whole mental health system exists for the *care and treatment* of the patient. Six principal objectives enter into the patient's care. The patient needs to be given pleasant surroundings, to be properly sheltered, comfortably bedded, generously fed, provided with adequate facilities for his personal maintenance, and kept busy with activities that contribute to his rapid recovery. Of course each hospital should have adequate therapeutic programs — psychiatric, general medical, and other—coordinated under competent direction, in order that they can be used promptly and effectively for all patients.

PERSONNEL

Few if any state hospitals for the mentally ill meet the standards recommended by the American Psychiatric Association with respect to the required numbers of physicians, psychiatrists, clinical psychologists, nurses, psychiatric social workers, and other therapists. Proper

* In the planning and conduct of the study, the Council of State Governments has had the advice and assistance of an exceedingly able technical advisory committee. New Jersey was represented on the Committee in the person of the Hon. Sanford Bates, Commissioner of the Department of Institutions and Agencies.

care and effective treatment of patients cannot be provided unless competent personnel in sufficient numbers are made available. All states should carefully appraise the personnel situation in state hospitals and should make every effort to provide the necessary professional and semi-professional staff.

More extensive and effective in-service training programs for all grades of personnel should be provided in state hospitals.

LEGAL ASPECTS

The Council recommends the modernization of our legal terminology. In New Jersey, and in many other states, the word "insane" appears on the commitment papers, thus introducing an emotional block when a relative is asked to sign a document declaring that his or her loved one is "insane". The hospitals in New Jersey, and in many other places, are legally stigmatized by being designated officials as "hospitals for the insane". Some states use "certification" instead of the blunter and more distasteful word "commitment". In too many jurisdictions, however, (including New Jersey) the word "commitment" is retained. Courts, sheriffs, "lunacy commissions", arrests, detention and transportation by the police, the swearing out of warrants, and even "trials" feature the processing of the mentally ill in many states—thus giving mental disease some of the symbolic tokens of criminal behavior. It is also recommended that provisions be made for continuing staff review of the condition of patients and for the wider use of conditional release, trial visit or discharge.

THE AGED

The problem of the aged is one of first order of magnitude and likely to increase. Many senior patients are sufficiently improved to be released if there were an appropriate place outside to which they could be sent. Many of these people cannot be sent back to their families. Some have no families. The state mental hospital thus tends to become a home for the aged. It may be that arrangements at local levels would reduce some of the pressure on the mental hospital with respect to the aged. An active local social service program, for example, might attempt to secure a home with more "elbow room" and less bustle for an aged person where he or she would be less likely to reach the breaking point than would be the case in a crowded hectic type of home. The local provision of recreation programs for old folks would probably help to keep them in active enjoyment. Counsel and aid with respect to legal, financial, dietary, and social problems would also go some distance toward reducing unnecessary mental strain on elderly folk. Such services are undoubtedly needed in the larger centers of population, and an "Old Age Guidance Center" may well be an important element in a humane and economical program.

CHILDREN

Psychiatric facilities for pre-psychotic and psychotic children are being provided either by alteration of present state hospital space or by construction of separate units under the sponsorship of various authorities. The trend is in the direction of integrating such special services with the existing state mental health program. In this connection the report refers favorably to the Arthur Brisbane Child Treatment Center at Allaire, New Jersey.

MENTAL HYGIENE CLINICS

Mental health clinics have been established and extended in practically all of the states, especially in recent years. Much greater use could be made of such facilities to the advantage of the community and the patient. Clinic and community care is more economical than institutional treatment. Local governments and other local institutions and agencies should participate actively in these programs, and community facilities of all types should be used extensively.

RESEARCH

More resources and facilities should be provided for comprehensive and intensive research in the field of mental illness; more attention should be given this subject in state hospitals and medical schools; every effort should be made to coordinate research programs and activities that now exist; and the states should encourage and support professional associa-

tions, institutions, and agencies in giving careful consideration to the development and expansion of major research programs in this field.

If mental illness could be combatted in the same manner as have been bubonic plague, yellow fever, typhoid, diphtheria, smallpox, and many other diseases, the potential value to the nation would be immense. The discovery of a cure for one disease entity—schizophrenia—would empty one-half of the mental hospital beds and — more important — keep them from being refilled. Even without such a radical discovery, the day-by-day work of steady, painstaking research would shed light not only on mental illness, but also on the psychology of everyday living. Knowledge so secured might pave the way for a better understanding of human relations and human behavior generally.

135 West Hanover Street

DIRECTORY OF SERVICES TO THE HANDICAPPED

Where can I get special services for the hard-of-hearing or for the blind? A speech-training instructor for a stutterer? Special appliances for a spastic? Questions like these and a dozen others are answered in the *Directory of Special Services for the Handicapped,* a practical booklet, which will be sent gratis to any member of this society. Send your request to the Executive Offices at 315 West State Street, Trenton 8. The services are grouped in 12 categories as follows: (1) For the blind and partly blind; (2) for epileptics; (3) for cerebral palsy; (4) for the deaf and the partly deaf; (5) for the intellectually retarded; (6) for the crippled; (7) for emotional and personality handicaps; (8) for the correction of spastic and congenital defects; (9) for poliomyelitis; (10) for rheumatic fever and heart disease; (11) for tuberculosis; and (12) for speech defects.

BOOK REVIEWS

A Textbook of Gynecology. By Arthur Hale Curtis, M.D. 6th ed., with 466 illustrations. Pp. 799. Philadelphia, W. B. Saunders Co., 1950. ($10.00)

From the title one would expect that surgical technic would be a major consideration but, with few exceptions, surgery receives secondary emphasis. The sixth edition follows the general outline of previous editions. There have, however, been extensive revisions and additions to nearly every chapter, broadening the scope by some 57 pages and bringing the subject matter up to date. The drawings, photographs and photomicrographs greatly enhance the script. Many of the illustrations are in color.

The authors have given us a comprehensive didactic summation of all the ills to which the female genito-urinary tract is heir, not only from their own vast experince but also from numerous references. The great amount of time and effort expended in making this book an outstanding contribution is at once evident. Each subject is so correlated that the history, etiology, pathology, symptoms, diagnosis and treatment, (including in many instances numerous illustrations) are made clear and concise thus making for easy reading. This is a good textbook for students as well as a handy reference for the physician.

ALBERT S. HARDEN, SR., M.D.

Handbook of Obstetrics and Diagnostic Gynecology. By Leo Doyle, M.S., M.D. Illustrations by Ralph Sweet. Pp. 240. Palo Alto, Calif., University Medical Publishers, 1950. ($2.00)

It can be doubted whether a publication of this kind (pocket-book size) serves a useful purpose. But the author of this small work supplies the answer. It is astounding how much of our present knowledge he has compressed into this small book, and even more amazing, is his unusual ability to organize the material. Thus, his compendium becomes an excellent help to the student and to the general practitioner; and the specialist too can profit from it in many instances.

BENNO LIDGNER, M.D.

Book Reviews continue on page 577.

STATE ACTIVITIES

TRUSTEES' MEETING

NOVEMBER 12, 1950

The following actions were taken at the regular meeting of the Board of Trustees on November 12, 1950, held at the Executive Offices, Trenton.

(1) Mrs. Edith L. Madden, Executive Assistant, appointed Acting Executive Officer.

(2) Plaque in tribute to Dr. LeRoy A. Wilkes, Executive Officer, 1933-1942, authorized.

(3) Special committee appointed to define the duties and supervise the activities of the paid employees of the Society.

(4) Public Relations Committee directed to continue monthly Membership News Letter.

(5) Co-sponsorship by Society with State Department of Health of four day civil defense course to be presented by State Civil Defense Organization authorized.

(6) Dr. Crowe, Dr. Greifinger and Dr. Murray named as Society's representatives to A.M.A. Conference on National Education Campaign, Cleveland, December 7.

(7) Mr. Bryan named as Society's representative to A.M.A. Public Relations Conference, Cleveland, December 3 and 4.

(8) Resolution from New Jersey Neuropsychiatric Association, condemning the practice of dianetics, referred to State Department of Education.

(9) Representatives named to A.M.A. Legislative Conference in Philadelphia, November 28—Chairman of the Board, A.M.A. Delegates, Chairmen of Welfare and Subcommittees, Executive Secretary of Legislative Committee.

(10) County educational program on health needs, desires and facilities of the county, to be offered by the Governor's Committee on Local Health, approved, and county societies to be requested to cooperate and have representatives attend the meetings.

(11) Special Committee appointed to draft resolutions in recognition of the long services to Society by Dr. Thomas B. Lee of Camden who died recently.

(12) Christmas bonus to full time employees authorized.

(13) The Journal and Membership News Letter to carry item that *Directory of Special Services for the Handicapped* is available free to any member requesting copy from Trenton offices.

(14) Work to date of Civil Medical Defense Committee approved; committee authorized to make necessary nominations to Civil Defense Organization for district and area chiefs and deputies as requested.

DR. ALLMAN RETIRES FROM PRIVATE PRACTICE

On the 35th anniversary of the opening of his office, Dr. David B. Allman, senior surgeon to the Atlantic City Hospital, retired from private practice. It was on November 10, 1915, that Dr. Allman announced the opening of his office for private practice. And on November 10, 1950, he announced its closing. Dr. Allman is president of the State Board of Medical Examiners, diplomate of the American Board of Surgery and chairman of the Board of Trustees of this Society. He is one of our delegates to the A.M.A. and expects to attend the 1951 Annual Meeting in that capacity. Dr. Allman is medical director of the Betty Bacharach Home and a Fellow of the American College of Surgeons.

LECTURES ON ALLERGY

Dr. Arthur F. Coca will deliver four lectures on the diagnosis and prevention of allergic diseases at the New School for Social Research, 66 W. 12 Street, New York. The dates are January 23, 24, 30 and 31, 1951. Lectures will begin at 8:30 p. m. and end at 10:15 p. m. Fee for the entire course is only $8.00. To register write to the Registrar of the school at the 12th Street address.

WITH NEW JERSEY MEDICAL AUTHORS

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OPHTHALMOLOGIC CONFERENCE

The third Annual Clinical Conference of the Wills Eye Hospital, Philadelphia will be held at the hospital, March 16 and 17, 1951.

As in other years, papers which reveal the latest development in ophthalmic treatment and procedures will be presented by many of the nation's outstanding ophthalmologists.

SUPPLEMENTARY LIST No. 8 TO THE 1950 OFFICIAL LIST

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Arnoff, Solomon, 70 Columbia ter., Weehawken (9)
Baeder, Robert L., 6 Rugby rd., Cedar Grove (7)
Buechle, Carl F., 61 S. Munn av., East Orange (7)
Epstein, Martin, 196 W. State st., Trenton (11)
Fine, Sydney G., 868 Stuyvesant av., Trenton (11)
Gribben, James A., 836 W. State st., Trenton (11)
Hammell, Frank M., 137 S. Main st., Allentown (11)
Kerns, Francis J., 526 W. Market st., Newark (7)
Kley, Edward, 32 Lexington dr., Livingston (7)
Lamb, Richard R., 887 Bellevue av., Trenton (11)
Marshall, John F., 129 Perry st., Trenton (11)
McCarthy, Cornelius P., 887 Boulevard, Bayonne (9)
McCormack, Raym'd A.,873 Bellevue av.,Trent'n(11)
McCormick, Robert, West Main st., Boonton (14)
Olinger, Mervin G., Essex County Sana., Verona (7)
Parker, James W.,Jr.,179 Shrewsb'y av.,R.Bank(13)
Perina, Anson, 48 Ridgewood av., Irvington (14)
Shechner, Isadore, 91 Third av., Newark (7)
Sheehan, George A., 27 Irving pl., Red Bank (13)
Taylor, Earl S., 18 Stockton pl., Princeton (11)
Tichenor, Clifford, 154 Irvington av., S. Orange (7)
Watkins, Eugene L., 40 Franklin st., Morrist'n(14)
Young, William V., Mount'nside Hosp., Montclair(7)

ASSOCIATE MEMBERS

Freeman, Robert F., 1230 Raritan av.,Highl'd P.(12)
Gearren, John B., 100 Farnsworth av.,Bordent'n(11)
Johnkins, Rowland, 756 Stuyvesant av.,Irvington(7)
Roberts, Montague, 533 Mt. Prospect av., Newark(7)
Ross, Wayne D., 100 Main st., Orange (7)
Wallis, Josiah K., 230 Nassau st., Princeton (11)
Williams, Hugh R., 55 No. Fifth av.,Highland P.(12)

OBITUARIES

DR. HORACE D. BELLIS

Dr. Horace D. Bellis died at his home in Trenton on November 4, 1950, at the age of 72.

A graduate of Yale University Medical School in 1907, Dr. Bellis held membership in the Society of Surgeons of New Jersey, Philadelphia Medical Club, Yale Club of Philadelphia, and was a Fellow of the American College of Surgeons. He practiced surgery in Trenton for the last 40 years. He was resident surgeon at St. Francis Hospital from 1915 until 1948, when he was named surgeon emeritus.

DR. THOMAS B. LEE

Dr. Thomas B. Lee, chief of the department of gynecology of Cooper Hospital, died on October 17, 1950.

Dr. Lee was born in Glassboro in 1881, and was graduated from Jefferson Medical College in 1905. He interned in Cooper Hospital and practiced in Camden.

Dr. Lee was a past president of the Camden County Medical Society, and had served as chairman of the Board of Trustees of The Medical Society of New Jersey. He was executive committee chairman of the New Jersey Division of the American Cancer Society. He was a member of the Philadelphia Obstetrical Society and the American College of Physicians.

DR. JAMES F. NORTON *

At the untimely age of 57, Dr. James F. Norton, past-president and Fellow of this society, recent vice-president of the A.M.A., and one of the country's top leaders in the profession, died on September 27, 1950. He died on the eve of his installation as medical director of the Jersey City Medical Center.

Born and brought up in Jersey City, Dr. Norton received his baccalaureate degree from St. Peter's College in 1914 and his M.D. from Columbia University in 1918. After an internship at St. Vincent's Hospital (New York) he accepted a residency in gynecology and obstetrics at Sloane Maternity Hospital. He engaged in the private practice of his specialty in Jersey City from 1921 until his death in 1950. He was attending obstetrician at numerous hospitals and was president of the medical staff at St. Francis Hospital. He served in many high offices in county, state, national and specialty medical societies. He had been a member of his native city's board of education, chief medical examiner of the Jersey City police department and a contributor of many valuable articles to the literature of gynecology, obstetrics, and medical economics.

DR. EDWARD W. ROSSELL

Dr. Edward W. Rossell, who practiced medicine in Camden for 32 years, died at his home in Colwick on September 29, 1950.

Dr. Rossell received his medical degree from the Medico-Chirurgical Medical College, Philadelphia, in 1904, and also was graduated from the Philadelphia College of Pharmacy. He was an emeritus member of the Camden County Medical Society and The Medical Society of New Jersey.

*See pages 454 of the October Journal and 527 of the November Journal for editorial and resolution on the death of Dr. Norton.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Leonard B. Erber, M.D., Reporter

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, October 13, 1950, Dr. G. Ruffin Stamps presiding.

Dr. William F. Rienhoff, Jr., associate professor of Surgery, Johns Hopkins University, was the guest speaker. His subject, "The Surgical Treatment of Hyperparathyroidism", was ably presented.

Dr. Clarence S. Steigerwald, chairman of the Atlantic County Selective Service Board, explained, at the request of the president, the application of the new doctor draft law. This had been fully outlined in the October Bulletin, but Dr. Steigerwald was able to answer more fully some of the questions that arose, and his talk did much to clarify the situation.

Dr. Salasin, reporting for the Public Health Committee, stated that Public Health Week, supervised by the State Society, will this year incorporate Diabetes Detection Week in its extensive program. Dr. Holland, secretary of the Public Health Committee, elaborated on this program, stating that on five days there will be four radio programs daily, each consisting of a five minute talk. These programs have been arranged by Dr. R. Harley, and have been planned so that each day will be devoted to an exhaustive coverage of a single topic, such as tuberculosis, heart disease, diabetes, etc. An added feature will be a Poster Contest to be conducted in the high schools in the county, with cash prizes as an inducement, the posters to be displayed during the week at the Electric Company, Blatts and similar prominent places. Dr. Holland explained that there was a considerable monetary outlay in a project of this nature, and asked for the financial support of the Society. It was accordingly voted that a budget of $250 be allotted to the Public Health Committee for expenses incurred in the promotion of Public Health Week.

Dr. Allman, reporting as chairman of the Committee on Arrangements for the 1951 Session of the A.M.A., stated that since the list of appointments as printed in the October Bulletin had been made, he had received notification from Dr. Lull that only Fellows of the A.M.A. may so participate. He explained that for an additional expenditure of $12.00, a Member may become a Fellow, and he urged this course to the members of the Society. If this request is not complied with, the names of the non-Fellows will be deleted as members of the various committees.

Speaking for the United Fund Drive, Dr. Allman asked for the support and cooperation of the Society as individuals. He commented on the public opinion of the medical profession's lack of response to these drives, and added that this was a most worthy cause.

Under old business, Dr. Holland announced that at the request of the State Society, the local Society would formulate a plan for emergency 24-hour medical service which will be adequately advertised to the laity.

The following were elected to membership: Associate membership — Dr. Eugene T. Pashuck; Regular membership — Drs. Julius Winston, Morton W. Leach and H. Emerson Burkhardt.

Dr. Myrtile Frank asked for some action by the Society on the revision of fees in Child Welfare cases. In the absence of Dr. Timberlake, chairman of the Welfare Committee, Dr. Stamps stated that the matter is now under advisement by that committee and that its action would be later reported.

Dr. Whims, reporting for the Program Committee, announced that Dr. Priscilla White, noted authority on Diabetes, would be the guest speaker at the November meeting, and urged all members to attend.

BURLINGTON COUNTY

Freeman W. Metzer, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on October 12, 1950, at the Riverton Country Club. The meeting was presided over by Dr. R. W. Betts, president.

The scientific portion of the meeting was presented by Dr. J. Edward Berk, who is assistant professor of Medicine at Temple University School of Medicine. In the time at his disposal, he discussed the "Diagnostic Features of Pancreatic Diseases". His talk was most informative and comprehensive.

The chairman of Civilian Defense, Dr. E. Warren Rodman, announced the County Society's plans for the program for this year. It is to consist of a Symposium on "Your Defense Against Atomic Bombing" which is to be held at the Rancocas Valley Regional High School, Mount Holly, on Wednesday, November 15, at 8 p. m. Dr. Oppenheimer, radiologist at Burlington County Hospital, Mount Holly, is to be the principal speaker. He is to be assisted by Drs. Bauer, Reagan, E. V. Davis, and Van Meter, as well as Mr. Powell, administrator of Burlington County Hospital in Mount Holly.

Dr. R. A. Haldeman, chairman of Procurement and Assignment for the county, reported the progress his committee has made in its effort to classify the physicians under 50 years of age in the essential and near essential groups.

CAMDEN COUNTY

L. G. McAfoos, Jr., M.D., Reporter

The Camden County Medical Society held its second regular meeting of the 1950-51 season on November 7, 1950, at the City Dispensary Building, with President O. R. Kline presiding.

Dr. Kline introduced Dr. Harrold A. Murray, first vice-president of The Medical Society of New Jersey, who spoke concerning the current activities of the State Society.

The guest speakers of the evening were Dr. John W. Hope of the Department of Roentgen-

ology, and Dr. James M. Walker, Department of Surgery of the Medical School of the University of Pennsylvania, who spoke on "Some Problems to Be Considered in Preparing for a Possible Atomic Bomb Disaster". Dr. Hope discussed the details of the physics of atomic energy. Dr. Walker spoke of the various degrees of injuries and burns which would occur in different vicinities of an atomic bomb disaster. He emphasized the importance of the close cooperation between the Civilian Defense and Red Cross Units of a disaster area.

Dr. W. Crist, chairman of the Medical Section of Camden County Civilian Defense, announced that a program for Civilian Defense in the Camden County area was formulated, and that close cooperation with the Philadelphia district would be carried out.

Dr. Ellis, chairman of the Diabetes Detection Committee, outlined a campaign for the detection of this disease, and stated that the Health Department will examine free of charge, urine specimens during Diabetes Detection week and that the druggists will act as collectors of these specimens. Dr. Ellis also asked the doctors to do sugar tests free of charge during this week.

Dr. A. G. Pratt read a memorial on the death of Dr. Edward W. Rossell. Dr. J. S. Shipman read a memorial on the death of Dr. Thomas B. Lee.

Dr. H. D. Barnshaw, reporting for the Community Chest, thanked the doctors of the community for their contributions stating that he felt that it was a respectable showing in view of the fact that the local hospitals did not participate in this drive.

ESSEX COUNTY

Elizabeth R. Brackett, M.D., Reporter

The opening dinner meeting of this season's activities was held on October 18, 1950, at Hotel Essex House in Newark, with Dr. Otto Matheke, Sr., the president in the chair.

A large group of members and their wives were present to hear an excellent presentation by Dr. William G. Herrman, Chairman of the Committee on Procurement and Assignment of The Medical Society of New Jersey. Dr. Herrman outlined the necessity of gathering accurate information concerning the "physician resources" of the state in order to plan efficiently for adequate professional personnel to meet the requirement for home services for the civil population and civilian defense and at the same time fulfill military requirements.

Mrs. Jesse Glazier brought a message from the Woman's Auxiliary and the Doctor's Chorus added greatly to the enjoyment of the occasion by several spirited renditions.

On November 13 we held our second meeting of the year by opening the exhibit on "Public Health in Peace and War" arranged in cooperation with the Newark Museum.

This meeting was the introduction to the observance of Public Health Week and because of its public character the usual business of the organization was postponed.

Our president, Dr. Otto Matheke, Sr., presided and after introducing several honored guests, who made brief addresses, he presented the speaker of the evening, Lt. Col. Mervin B. Forbes, from Fort Monmouth's Signal Corps Engineering Laboratory. Col. Forbes is an authority on preparation for atomic attack and emphasized a few important precautions to be taken in the event of an attack as well as indicating the manner in which atomic bombs produce their destruction. His talk was exceedingly interesting and informative.

Preceding the meeting a moving picture on atomic warfare was shown and following the meeting the exhibit was opened to the public.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

President A. Guy Campo acted as Toastmaster at the Annual Ladies' Night and Social Session of the *Gloucester County Medical Society* held at the Woodbury Country Club, October 19, 1950. The guest of honor, Dr. Aldrich C. Crowe, president of the State Medical Society, gave a few choice remarks.

While listening to music by the famed La Gitana Trio a delicious steak dinner was enjoyed by the ninety-one present. State Senator Harold Hannold and Congressman Charles A. Wolverton made some interesting comments.

Mr. Ivan H. Peterman, newspaper correspondent and columnist, delivered the principal address of the evening. Speaking on the general subject, "East Versus West" Mr. Peterman drew from his experiences as a war correspondent and subsequently of his trip into Russia, as a background for his comments on the United Nations. Following his talk, the speaker answered a number of questions put by members of the interested audience.

The committee on arrangements consisted of Drs. Louis K. Collins, James G. Kehler, and Albert J. Battaglia.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its November meeting jointly with the Woman's Auxiliary to the Society on November 8, 1950, at Murdoch Hall, Jersey City Medical Center. Dr. Noah Meyerson presided at the Executive Session.

Committee on Constitution and By-Laws, under chairmanship of Dr. A. C. Ruoff, reported that the revised edition of the Society's Constitution and By-Laws is about ready for publication.

The following were elected to membership: Drs. Charles L. Cunniff, Hugh E. Flood, Richard L. Franklin, Jacob B. Mandel, James A. Stevenson, Gerald L. Winokur all of Jersey City; Dr. Edward F. Cannon of Leonia; Dr. Charles J. Modero of Hoboken; Dr. Frank J. Primich of Weehawken, and Dr. Ross Simpson of Bayonne.

Dr. John A. Morrone of Jersey City and Dr. William Eckert of Union City were reinstated to active membership.

Mrs. John J. Muccia, President of the Woman's Auxiliary, was introduced by Dr. Meyerson. On behalf of her associates, she expressed appreciation for having been invited to participate in this meet-

ing with the parent society, and the hope that this first joint meeting would mark the beginning of a new comradeship and much shared activity in the future. The Auxiliary is keenly desirous of fufilling its mission of *helper* to the Hudson County Medical Society, said Mrs. Muccia, and it therefore welcomes every opportunity to be of service.

Dr. Sigurd W. Johnsen, President-Elect of The Medical Society of New Jersey, brought the greetings of the State Society to the combined assembly, and paid special tribute to the Woman's Auxiliary for the active role it is playing in state, as well as in county medical matters. The balance of Dr. Johnsen's address was devoted to eulogizing the immediate past-president of The Medical Society of New Jersey and his friend, the late Dr. James F. Norton of Jersey City. Dr. Johnsen paid tribute to the character of Dr. Norton, emphasizing his talents, his oratorical ability, the personal traits that marked him a leader among men and a crusader . . . yet withal a humble, sincere, and gracious gentleman. He closed using the words of St. Paul in final tribute to Dr. Norton:

> "I have fought the good fight. I have finished my course. I have kept the faith: Henceforth there is laid up for me a crown of righteousness which the Lord, the righteous Judge, shall give me on that day."

The light note of the meeting was sounded by Mr. Paul Benson of New York, who in a short period of fun-making cajoled his audience into participating in an "aptitude test". The most *apt* received appropriate prizes.

The feature attraction was the First Annual Hobby Show, conceived and directed by Dr. Louis L. Perkel, with the assistance of Mrs Perkel. Many members, both of the Society and of the Auxiliary, exhibited specimens of their avocational interests. Attractively arranged in Hobby Hall, were exhibits of paintings in oil and water colors, work in combined brass and wood, stamp collections, and photography (including salon and third-dimensional); published full-length books and lyrics, ceramics, crocheted bedspreads, and examples of dress design and children's apparel; a collection of pipes and of Bavarian steins; several prize-winning ship models, and a scrapbook of self-authored magazine and newspaper articles. (With Mrs. Perkel and Miss Carrega of Murdock Hall in attendance, the Hobby Exhibit was on display all evening, beginning at 8 p. m.)

At the close of the meeting, Dr. Meyerson expressed his appreciation to the Woman's Auxiliary, to Dr. Johnsen, to Dr. and Mrs. Perkel, and to all others (including Mr. Benson) who contributed in any way to the enjoyment of this first joint meeting of the Society and its Auxiliary.

HUNTERDON COUNTY

H. A. Davidson, M.D., Reporter

The regular meeting of the *Hunterdon County Component Society* was held on October 25 at the Clinton House, in Clinton. Most of the members were present. The chair was occupied by Dr. L. A. Hamilton, president of the society who, after the regular business meeting had been concluded, introduced the guest speaker, Dr. Horland of Newark. Dr. Horland spoke on the role of the general practitioner in modern medicine and then briefly discussed the problem of interpretation of heart murmurs. Next speaker, Dr. Ray Trussell, Administrator of the Hunterdon Medical Center, asked for and received a resolution urging a county-wide survey to determine the needs of the chronically ill in Hunterdon County. The Society then elected Dr. William E. Boutelle of Pittstown into full membership, on transfer from the New York County Society, and received one other application for membership which was referred to the Board of Censors.

MORRIS COUNTY

Theodore R. Failmezger, M.D., Reporter

The first meeting of the *Morris County Medical Society* was held on November 19, 1950, at the Chilcott Laboratories Division of the Maltine Company in Morris Plains, with an excellent attendance. After a short business meeting Dr. Robert P. McCombs, professor of Medicine, Tufts Medical College, Boston, Mass., and medical director, Pratt Diagnostic Clinic, Boston, Mass., was introduced by the chairman of the Program Committee, Dr. Paul B. Patton.

The subject of the evening was "Steroid Hormones, Their Practical Use in Surgery and Medicine with Special Reference to *ACTH* and *Cortisone*". Dr. McCombs illustrated his extremely interesting discussion with lantern slides, and after a rather prolonged discussion the group adjourned to the Cafeteria where the Maltine Company supplied a buffet supper.

PASSAIC COUNTY

Leopold E. Thron, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held on October 17, 1950, at 9:00 p. m., at the Woman's Club, Paterson. The president, John E. Leach, M.D., presided at the meeting.

The following physicians were elected to Active membership: Alben G. Peters, M.D., and Arthur A. Rosenthal, M.D.; to Associate membership: Miriam H. Winkler, M.D., and Milton E. Landman, M.D.

Mr. Frank Davies explained to the members provisions in the Soldiers' and Sailors' Act of 1940 which would be of benefit to them when called into service.

Resolutions on the death of Herman Achtentuch, M.D., and Archibald F. Graham, M.D., were read and adopted.

Dr. Ash reported for the Building Committee and Dr. Levinsohn announced that a letter would be forwarded to those members who have not as yet paid their assessment, as every day's delay means a loss to the Society and to each member. After full discussion of the plans for alterations, costs, etc., it was moved, seconded and passed that: The Building Trustees go ahead with the proposed plans for a meeting in the basement of the building and that they be empowered to expend monies not exceeding the sum of $20,000.

Dr. Andrew F. McBride, Jr., introduced the

speaker of the evening, HENRY M. BERLINER, M.D., Colonel, Medical Corps, United States Army Reserve Corps, and neuropsychiatrist at Lyons Hospital. Dr. Berliner's address was on the "Medical Aspects of Atomic Radiation" and he very thoroughly covered the first effects of an atomic bombing, the severe trauma, radiation and radiation illness.

SALEM COUNTY

John S. Madara, M.D., Reporter

With its new president, DR. AUGUST JONAS, officiating, the first fall meeting of the *Salem County Medical Society* was called to order at the DuPont-Penns Grove Country Club at 4:30 p. m., on September 22, 1950.

The meeting opened with a discussion of ACTH—its action, dosage, cost, indications and contraindications— by MR. REISEN and MR. COOMBS, representatives of Armour Laboratories.

There followed a discussion of Public Health Week by Dr. Harry F. Suter. A committee was formed (Drs. Suter, Madara and Miller) to formulate a plan to bring this week to the attention of the public.

A Salem County Heart Committee was formed (Drs. Suter, Wetherhold and Silverman) to coordinate the county activities with those of the state.

A letter from the Woman's Auxiliary Health Council concerning the improvement of school health services was read and approved in principle, and Dr. C. S. Fleming was appointed to the committee.

DR. FORD C. SPANGLER was accepted as a member of the Society on condition his credentials from the A.M.A. be acceptable.

The regular monthly meeting of the *Salem County Medical Society* was held at the DuPont-Penns Grove club on October 20, 1950, at 4:30 p. m., with DR. AUGUST JONAS presiding.

The speakers-of-the-day were introduced by the chairman of the Program Committee, Dr. R. L. Silverman. DR. J. STANLEY COHEN, of Philadelphia, read an interesting and very timely paper on *The Practical Application of Sedation and Anesthesia in Obstetrics,* with particular emphasis on the use of Demerol and Scopolamine, and Spinal Anesthesia. DR. JOSEPH GROSSMAN, also of Philadelphia, discussed *Factors Concerning Neonatal Mortality and Morbidity,* including prematurity, cerebral hemorrhage, erythroblastosis fetalis, epidemic diarrhea, congenital anomalies, and respiratory disease.

Plans for Public Health Week (November 12-18) were presented by Dr. John S. Madara: (1) mimeographed brochures to be distributed to each of the doctors in the Salem County Medical Society for the enlightening of his patients: (2) an Open Forum for the public to be held in the Salem High School on November 16, at which six doctors will discuss school health, maternal welfare, cancer control, heart disease, civilian defense, and recent advances in medicine, to be followed by a question-and-answer period.

SUSSEX COUNTY

Martin I. Kirschner, M.D., Reporter

The Fall meeting of the *Sussex County Medical Society* was held on October 10, 1950, with DR. LEO DRAKE, presiding.

Guest speaker was DR. THOMAS ALMY of the New York Hospital. His subject was "The Irritable Colon and Colonic Cancer—A Double Challenge". This was a most excellent presentation, and was the last of the lecture series prepared by the Post Graduate Committee of our Society.

DR. JOSEPH COLEMAN was presented with an automatic lighter and other attachments, in recognition of fifty years' service in medicine, and for many years a Trustee of the State Medical Society. He responded with his familiar "old time stories of old time doctors".

Dr. Spencer was appointed chairman of a committee to investigate and make recommendations on equipment for use in polio cases. The Freeholders of Sussex County have shown an interest in the purchase of such equipment.

It was voted not to hold a lay Public Health Week this year.

A resolution was passed to inform all municipalities in the county of the Society's opposition to the sale of unpasteurized milk, and also the dipping of milk for school children from large containers.

Dr. Coleman was named the Procurement and Assignment Officer for the Society, and each member was urged to fill out his questionnaire and return it to the Trenton office.

WARREN COUNTY

Lewis E. Genninger, M.D., Reporter

The meeting of the *Warren County Medical Society* was held on October 17, 1950, at the Elks Club, Washington.

A motion was passed that the Welfare Board be informed that a qualified ophthalmologist, Dr. Vincent Burell of Phillipsburg is now available in Warren County.

DR. BURELL and DR. CATHERINE KRAUSZ were accepted as members upon the recommendation of the censors.

DR. SIGURD W. JOHNSEN, President-Elect of the State Society, spoke on the following: Procurement and Assignment Committee, recent changes made in the number of sections of the annual State Convention, the role of the local and State Judiciary Committee, and the relation of hospitals to the practice of medicine.

A motion was made and seconded that the president be empowered to appoint a committee of three members, all over 50 years of age, to act as a Procurement and Assignment Committee. The following were appointed: DRS. BLOOM, DRAKE and SPILLANE.

The president also appointed a Judiciary Committee consisting of DRS. BLOOM, HUMBERT, BARTOLINI, MARLETT and MAXWELL.

A motion was also made that the Judiciary Committee study the development of a minimum fee schedule and report on same at the next meeting.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. R. John Cottone

A very Merry Christmas to all Auxiliary members and their families.

In my visits to the counties I have observed with much pride the steady progress of our work. The gain in membership shows we are all working toward the goal of a stronger State Auxiliary. Let us extend to our new members everywhere a special welcome at this Holiday Season.

Gift-giving is a very special part of our American Christmas and the greatest gifts come from the heart. The more we give of kindliness and thoughtfulness, the more we have for ourselves, which is a gratifying reward. Let us remember the ill, the bereaved and the lonely in our membership. Make it a happy time for them and our own happiness is assured.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Winn,
Chairman, Press and Publicity

The first meeting of the *Woman's Auxiliary to the Medical Society of Atlantic County* was held at the Traymore Hotel on October 13, 1950, with Mrs. Clarence Whims presiding. At this time we were honored with the presence of Mrs. David B. Allman, immediate past president of the National Auxiliary and Mrs. Thomas H. McGlade, president-elect of the State Auxiliary.

Greetings were extended by Dr. G. Ruffin Stamps encouraging progress on nurses' recruitment, furthering better public relations, and directing emphasis on socialized medicine.

There will be a number of social events coming to the fore—first to be enjoyed will be the Hallowe'en party and dance to be held at the Atlantic City Country Club on November 4 at 9:00 p. m. This event is of major importance since it is the means of raising funds for the benefit of "The Student Nurses' Fund" which is our worthwhile local project. The choral group being newly organized will be another phase of entertainment for the Auxiliary.

Particular emphasis is being directed to nurses' recruitment and we anticipate a stride forward in this worthy cause. Our Nurses' Recruitment chairman extended, in behalf of the Atlantic City Hospital Staff, an invitation for our Auxiliary to conduct our next meeting at the nurses' home.

Bergen County

Mrs. Winton Johnson,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Bergen County Medical Society* held a covered-dish luncheon at the home of Mrs. Gustav Steneck, Bogota, on November 14, 1950. Thirty-seven members and two guests were present. The luncheon was a culinary triumph, and the committee responsible for its great success was made up of Mrs. Stewart Alexander, Mrs. Walter Jordan, Mrs. Danial Roth, Mrs. Joseph Basralian, Mrs. Carl Rothschild, and Mrs. Matthew Feldman. Mrs. Edward Ravits entertained with piano selections.

The business meeting was conducted by the president, Mrs. Edward Sexton, who called for committee reports on the progress of the Auxiliary's work. There are two newly formed committees in action, one devoted to Community Health, the other to the wider distribution of *Today's Health*. The plans for the annual Christmas Party which is a dinner-dance, were announced; it will be held on the evening of December 9, at the Oritani Field Club in Hackensack, for Auxiliary members and their husbands.

Mrs. Stewart Alexander introduced the speaker, Mrs. Robert Wheaton of Short Hills, N. J., who gave a very informative talk on the work being done by a unique charity known as "New Eyes for the Needy."

BOOK REVIEWS

Fractures and Dislocations in General Practice. By John Hosford, M.D. 2d ed. Rev. by W. D. Coltart, M.B. Pp. 280. New York, Paul B. Hoeber, Inc., 1950. ($5.00)

This book is intended for both medical students and general practitioners. The first seven chapters represent a basic treatise on fracture treatment and will be very helpful to students. The balance of the book covers the commoner fractures and dislocations using sound and generally accepted methods of treatment. Where open operation is needed, the indication is merely stated, the technical details being omitted as of interest only to the specialist. The book is clearly written, well-illustrated, and with certain qualifications, covers its field well. General practitioners will need more guidance than this book can give in recognizing certain late complications of fractures which may come to their attention.

An outstanding omission is the failure to mention the risk of aseptic necrosis of the femoral head following fractures of femoral neck. In general, however, this book can be recommended as a highly readable short text for students.

Bernard Chromow, M.D.

Medical Management of Gastrointestinal Disorders. By Garnett Cheney, M.D. Pp. 478. Chicago, Year Book Publishers, 1950. ($6.75)

This excellent textbook of gastroenterology is written by a clinician for the general practitioner. Focus is on the patient with gastrointestinal complaints from the moment he enters the office until he has received definitive treatment. The author starts with a discussion of history taking, then proceeds with physical examination, laboratory procedures, endoscopic and x-ray examinations, symptoms and disease entities. Controversial matter has been omitted to give a clear impression and a starting point for further investigation.

The format is arranged for clear and convenient reading. The book is a concise and practical guide to the management of the patient with a gastrointestinal problem.

Herbert B. Silberner, M.D.

Sexual Deviations. Louis S. London, M.D., and Frank S. Capiro, M.D. Pp. 702. Linacre Press, Washington 6, D. C., 1950. ($10.00)

Probably any book with the word "sex" in the title is certain to have a fairly good sale. The magnetism of the title thus relieves the authors from the need for offering a practical volume on treatment. In this book, for instance, the text runs for over 700 pages. However, the practical aspects of the problem are disposed of in a four-page chapter entitled "Prophylaxis, treatment and prognosis". It is naturally to this chapter that doctors, lawyers, judges and probation officers will turn for help in learning how to handle sex deviants. To prevent sexual deviations, the authors give only these instructions: don't let children overhear sexual relations, take care (but don't say how) in handling masturbation, and give sexual enlightenment free of taboos. Treatment is disposed of in a single sentence, something of a record for a medical book: psycho-analysis offers the greatest hope for cure, and that is that. If the physician can perform psycho-analysis, he scarcely needs a 700-page book to tell him that. If he cannot do psycho-analysis, the advice is useless. Another disappointing chapter is the one hopefully entitled "Medico-Legal Management of Sex Offenses". Here we are told that the nonpsychotic sex offender should "have access to psychiatric treatment on probationary status". This is proposed as an alternative to institutional placement, and a more hazardous bit of advice has seldom been given in a medical text. If the authors' recommendations are followed, the nonpsychotic child seducer, the one with a compulsion to rape children, and the one whose sexual drives lead him to repeated assaults and murders, would all be allowed to remain in the community on promise of daily or weekly outpatient psychotherapy.

Aside from these disarmingly simple chapters, the book is made up almost entirely of case reports —interesting, well-written, illuminating, but unapplicable to the day-by-day problem of managing the violent sex deviant in any socially safe and practical manner.

Henry A. Davidson, M.D.

The Merck Manual of Diagnosis and Therapy. 8th edition. Merck and Company, Rahway, N. J., 1950. Pp. 1592. ($5.00)

Here it is again, the old reliable *vade-mecum*, the fact-packed, down-to-earth handbook that, in various editions and revisions, has for fifty years been consulted (openly or surreptitiously) by practitioners and interns in need of a quick tip, an accurate dosage or a new suggestion. The first 1400 pages are devoted to specific diseases, with diagnostic and therapeutic suggestions, the latter being written with explicit dosage and interval advice. The rest of the book includes a miscellany of useful data such as immunization procedures, pre-operative routines, dosage conversion tables, diets, office laboratory procedures, alternatives to proprietary preparations, and the like. Suggested drugs are given their common names, even if this means using a well known proprietary trade-mark, and the publishers show commendable restraint in not favoring Merck preparations over other brands. The book is up to date and even includes the diagnosis and treatment of atom bomb injuries. *Merck's Manual* is so well known to physicians, and so respected by them, that the publishers need no blurb. The only difficulty may be in getting the book, since the first printing was completely exhausted by advance orders before the presses had stopped turning. A reprinting is promised for the near future.

Ulysses M. Frank, M.D.

Additional Book Reviews on pages 567 and 586.

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INDEX---1950

HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject; book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

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The Official List of Members and Fellows will be found as the Supplement to the April issue. The Transactions of the Annual Meeting appear as a supplement to the August issue.

The annual reports of the committees and officers of the Society are indexed on page 205 of the May Journal.

TABLE OF PAGES

January	1 to 46	September	409 to 452
February	47 to 96	October	453 to 496
March	97 to 144	November	497 to 544
April	145 to 190	December	545 to 588
May	191 to 258		
June	259 to 310	Annual Reports	May Journal
July	311 to 360	Official List	April Supplement
August	361 to 408	Transactions	August Supplement

KEY TO SYMBOLS

* Original Articles

† Obituary

e—Editorial

br—Book Review

ab—Abstract

A

Abramo, Anthony, Paterson *272
Academy of Medicine Graduate Week 534
Acne Vulgaris, Management of—Fanburg *19
Adoption Problem and the Physician 290
Adrenal Insufficiency, Diagnosis and Treatment of (G. W. Thorn) br141
Allies of Medicine e545
Alling, Frederick A.† 34
Allman, David B. 568
Allman, Mrs. David B., Atlantic City *442
American Medical Association—
Delegates, New Jersey, List of (Advertising page 3A each issue of The Journal)
Dues 84
National Advertising Program Announcement 348
Amphetamine in Obesity—Kalb *66
Anastomosis, Two-Layer—Evans *56
Anathion in Treatment of Arthritis—Libenson and Wittenborn *105
Anesthesia, Gynecologic—Tuohy *514
Annual Meeting, 184th e191, 339
Advance Announcement 76
Program 192
Annual Reports .... May Journal
Index 205
Anorectal Disease and Gastro-intestinal Disturbances—Gerendasy *421
Antabuse, Reactions to—Garber and Bennett *168
Antibiotics (edited by Irving and Herrick) .. br308
Antihistamines in Dysmenorrhea—Hoffman .. *287
Aphasics, Communication Chart for 527
Aphthous Stomatitis—Braitman *160
Arthritis, Rheumatoid, Treatment of—
Strazza *472
Tillis *475
Arthritis, Treatment of—Libenson and Wittenborn *105
Arthropathies (A. A. deLorimier) br405
Asthma, Bronchial—Hyman *14
Asthma, Muscle Pains of—Gordon *110
Atlantic County Medical Society 38, 87, 134, 183, 300, 350, 536, 572
Atlas of the Blood and Bone Marrow (R. P. Custer) br449
Atomic Medicine (edited by C. F. Behrens) ...br255
Autopsy Administration 176
Avulsion of the Biceps Tendon—
Goldenberg *114
Schlossbach *166

B

Babbitt, Hugh M., Plainfield *170
Baker, M. Edward, Camden *123
Balk, Jacob L., Newark *171
Ballistocardiography, Clinical Use of—Greenberg *434
Banthine in the Control of Duodenal Ulcer—Friedman *428
Barbiturate Poisoning, Immediate Treatment—Robie *370
Bellis, Horace D.† 571
Bennett, Robert E., Trenton *168
Bergen County Medical Society 183
Bernstein, Arthur, Newark *171, *504
Biber, David, Union *152
Biceps Tendon, Avulsion of—
Goldenberg *114
Schlossbach *166
Blood Procurement—Pons and dePons *331
Bluefeld, Curt, Jr., Nutley *426
Book Reviews 43, 93, 141, 187, 253, 255, 306, 347, 357, 405, 449, 493, 541, 567, 577, 586
(Listed alphabetically by title in general index and marked br)
Bookrajian, Edward N., North Bergen *332
Boric Acid Called Outmoded and Hazardous 398
Bossard, Harry B.† 297
Bowman, Ned, New Brunswick *68
Brain Injuries—Frisch *431
Brain Tumors in Children—Sandler *49
Braitman, Max, West New York *160
Bramble, Halsey S.† 491
Brandman, Otto, Newark *267
Breast, Carcinoma of—Jacobson *337
Breech Delivery—Johnson *465
Bronchial Asthma—Hyman *14
Brucellosis (H. J. Harris) br406
Brunner, Hans, Newark *375
Bryan, James E. 35, 131, e499
Burlington County Medical Society 38, 87, 134, 183, 300, 350, 536, 572
Burns, Treatment of 529

C

Cacciarelli, Robert A.† 397
Calcification of the Prepatellar Bursa—Babbitt *170
Camden County Medical Society 38, 87, 135, 300, 350, 537, 572
Cancer (See organ affected)
Cancer, Cytologic Diagnosis of br493
Cancer Crusade in New Jersey e261
Cancer, Iodo-acetate Index in—Gilbert, Goldberg, Tausz and Tausz *424
Cancer Problem—Demy *363
Cancer Program in New Jersey. Part V. *69
Cancer, Semantics of e98
Cannata, Benjamin V., Perth Amboy *415
Cappiello, William A., Newark *519
Carbon Monoxide Detection—Goldberg *382
Cardiologic Aspects of Certain Rheumatic Diseases—Dennison *4
Cardiology, Manual of (T. J. Dry) br494
Castronuovo, John J., Paterson *422
Cation Exchange Resins in Control of Cardiac Edema—Crossfield *554
Century of Medicine in Jacksonville and Duval County (W. Merritt) br306
Chest X-ray, Mass—Willner *120
Cheung, Sau Fong, Englewood *426
Chisholm, C. Brock, Ottawa, Canada *148

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book review
Annual Reports: May Journal
Official List: April Supplement
Transactions: August Supplement

Cholelith in Pyloric Obstruction—Ogden *512
Clinical Audiology (M. Saltzman) br93
Clinical-Laboratory Examinations (J. A. Kolmer) br94
Clinical Pathology (B. B. Wells) br358
Clinical Radiation Therapy (I. I. Kaplan) br187
Closed Brain Injuries—Frisch *431
Cogan, Henry† 491
Cohen, Samuel, Jersey City *557
Colby, Maxwell X.† 85
Colon and Rectum, Lesions of—Forte *283
Colon, Cancer of—Goldstein *482
Committee Chairmen, List of (Page 3A September, October, November and December JOURNALS)
Committee System e311
Committees, List of (Advertising page 4A May and July JOURNALS, page 3A September, October, November and December JOURNALS)
Common Cold, Hydryllin for—Kessler *29
Comora, Herman C., West New York *369
Congenital Anomalies of the Heart and Great Vessels (edited by P. Cannon) br255
Cooperating Agencies, List of (Advertising page 4A of May JOURNAL)
Copleman, Benjamin, Perth Amboy *415, *510
Corbusier, Harold D.† 491
Cord Tie, Simplified—Krakower and Nabolotny *440
Coronary Artery Disease (Boas and Boas) br43
Cortex, Partial Ablation of (edited by F. A. Mettler) br142
Cough-Pain Sign in Thrombophlebitis — Lawrence *164
Councilors, List of (Advertising page 3A, each issue of THE JOURNAL)
County Medical Societies—
List of Officers (Advertising page 7A May and July JOURNALS)
Meeting Dates 396
Cranial Nerve Paresis Following Anti-Rabies Vaccination—Rubin and Bowman *68
Craster, Charles V., Newark *395
Crecca, William D., Newark *519
Crossfield, Henry C., East Orange *554
Crowe, Aldrich C. e259, e260, e311, e409, e453, e497, e545
Cufari, Carmine J.† 34
Cumberland County Medical Society 39, 183, 350, 399, 537
Current Therapy—1950 (edited by H. F. Conn) br405
Cushing, Harvey (E. H. Thomson) br494
Cytologic Technic in Carcinoma—Jacobson *337

D

D'Acierno, Pellegrino A.† 297
Danzis, Max, Newark *548
Demy, Nicholas G., Plainfield *363
Dennison, A. D., Jr., Maplewood *4
Dental Crown in Nasopharynx—Schnee *124
dePons, S. C., Asbury Park *331
Derangements of the Hip—Halbstein *64
Dermatoses, Occupational—Hanfling *379
De Yoe, Leon E., Paterson *422
Diabetes Detection Drive 490
Diabetes, Diagnostic Errors in—Saslow *116
Diagnostic Errors in Diabetes—Saslow *116
Diagnostic Tests for Infants and Children (H. Behrendt) br187
Dickinson, Frank G., Chicago *262
Dictionary for Nurses (A. L. Price) br43
Dicumarol in Heart Disease—Schneider *161
Digestive Diseases, Handbook of (Kantor and Kasich) br187
Directory of Services to Handicapped 567
Diseases of the Heart (C. K. Friedberg) br141
Dissection, Manual of (edited by C. E. Tobin) br93
Drug Therapy Year Book (edited by H. Beckman) br256
Duodenal Ulcer, Banthine in the Control of—Friedman *428
Dysmennorrhea, Antihistamines in—Hoffman *287

E

Ectopic Pregnancy—Taber *464
Eisenstein, B., Jersey City *315
Electrocardiography (L. Wolff) br256
Endometriosis—
Bookrajian and Morrow *332
Newman *279
English, Harrison F. 127
English, Samuel B.† 34
Envelope, The (J. S. Plant) br358
Epilepsy, State, Plan 346
Erf, Lowell A., Philadelphia *479
Essentials of Gynecologic Endocrinology (G. M. Riley) br93
Essex County Medical Society 88, 135, 300, 351, 399, 573
Essex County Service for the Chronically Ill, Inc. 295
Evans, Charles Hawes, East Orange *56
Executive Officer, Need for e499
Exhibit, Indispensable c47
Eye and Its Diseases (edited by C. Berens) br253

F

F.A.C.S. or Diplomate in Surgery? 292
Fanburg, S. J., Newark *19
Federal Academy of Medicine e547
Foot, Diseases of (E. D. W. Hauser) br405
For the New Mother (M. V. Hardcastle) br357
Foreign Bodies in Eye, Removal of—Sherman *469
Forte, Frank S., Newark *283
Fractures and Dislocations in General Practice (J. Hosford) br577
Frank, Nathan, Jersey City *9
Frankel, Emil, Trenton *565
Freud: Dictionary of Psycho-Analysis (Fodor and Gaynor) br586
Friedman, A. I., Hackensack *428
Frisch, Felix, Trenton *431

G

Gall Bladder, Congenital Absence of—De Yoe and Castronuovo *422
Gambacorta, Otto, Bloomfield *61
Garber, Robert S., Trenton *168
Gas Bacillus Infection—Cappiello, Liccese and Crecca *519
Gastro-enterology, Postgraduate (H. L. Bockus, Editor) br406
Gastro-intestinal Hemorrhage—Tumen *455
Gastroscopist, Role of, in Diagnosis—Riese.... *388
Geary, Daniel J.† 85
General Practitioner, Role of, in 1950 Medicine —Horland *412
Gerendasy, J., Elizabeth *421
Geriatric Medicine (edited by E. J. Stieglitz).. br44
Gershenfeld, David B., Newark *374
Gerson, Stanley, Paterson *72
Gilbert, Samuel M., Newark *424
Gleason, James F., Atlantic City..... *270, *416
Gloucester County Medical Society.....39, 88, 135, 184, 301, 351, 399, 537, 573
Goldberg, H. C., Plainfield *382
Goldberg, Harold H., Newark *152
Goldberg, Samuel, West Orange *100
Goldberg, Samuel A., Newark *424
Goldenberg, Raphael R., Paterson *114
Goldstein, Henry Z., Newark *27
Goldstein, Hyman I., Camden 278, *482
Goldstein, J. D., Jersey City *315, *557
Goldstein, Samuel, Mays Landing *416
Gordon, Isaac L.† 447
Gordon, Samuel, Paterson *110
Graduate Medical Courses in Seton Hall..... 487
Greenberg, Max, Linden *434
Grossbard, Paul, Passaic *30
Gurland, B. Bernard, Bayonne *480
Gynecologic Anesthesia—Tuohy *514
Gynecologic Endocrinology, Essentials of (G. M. Riley) br93
Gynecologic Surgery, Mortality of—Tunis *483
Gynecological Histology (J. Barnes) br44
Gynecological Surgery and Instruments of, Development of (J. V. Ricci) br307
Gynecology, Medical (J. C. Janney) br450
Gynecology, Textbook of (A. H. Curtis)..... br567

H

Haddon Hall Highlights 339
Haemoglobin (edited by Roughton and Kendrew) br449
Haemolytic Disease of the Newborn (M. M. Pickles) br307
Hahn, William H. 295
Halbstein, Bernard M., Long Branch *64
Hamill, John, Jersey City *557
Hanan, James T.† 297
Handbook of Medical Management (Chatten, Margen and Brainerd) br142
Handicapped, Directory of Services to 567
Handwriting Analysis (U. Sonnemann)..... br542
Hanfling, Seymour L., East Orange *379
Harreys, Charles W.† 130
Haseltine, Sherwin L.† 130
Haven, Samuel C.† 34
Hawkes, Stuart Z., Newark *22
Health and Medical Care Program (of The Medical Society of New Jersey) 74
Heart, Spontaneous Rupture—Rath and Price..*390
Help Yourself to Better Sight (M. D. Corbett)..br43
Helpful Hints to the Diabetic (Collens and Boas) br307
Hematology—
Erf *479
Konzelmann *419
Hematoma, Intrapulmonary—Welkind *501
Hemorrhage from Upper Gastro-intestinal Tract—Tumen *455
Hemorrhagic Disorders—Moolten *517
Hepato-jejunostomy for Biliary Obstruction—Lewis *387
Hernia, Synopsis of (A. H. Iason) br43
Herz, Adolph J., Elizabeth *393
Hip, Arthritic Derangements of—Halbstein.... *64
Hoffman, David B., Newark *287
Holler, Henry G.† 85
Home Care for Cancer Patients *69
Horland, Aaron H., Newark *412
Hospital Publications e312
Hospitals and Free Enterprise e2, 179
Hudson County Medical Society.....39, 88, 135, 184, 301, 351, 399, 538, 573
Hughes, Frederick J.† 397
Human Growth (L. F. Beck) br405
Hunterdon County Medical Society 39, 136, 351, 447, 574
Hydatidiform Mole—Grossbard *30
Hydryllin for the Common Cold—Kessler *29
Hyman, Charles, Atlantic City *14
Hypersensitiveness to Insulin—Skwirsky *327
Hypertension, Treatment of—Parsonnet, Simon and Bernstein *504
Hyperthyroidism, Management of—Johnson.. *383

I

I Remember Papa 82
Ill, Edmund W.† 297
Immunology in Hematology—Konzelmann.... *419
Indispensable Exhibit e47
Industrial Medicine Course 525
Insulin Hypersensitivity—Skwirsky *327
Intern, Intern, Who Gets the Intern?..... e497
Intestinal Obstruction in Meckel's Diverticulum —Danzis *548
Intrapulmonary Hematoma—Welkind *501
Iodo-acetate Index in Cancer — Gilbert, Goldberg, Tausz and Tausz *424

J

Jacobson, Benjamin D., New Brunswick ... *337
Johnson, Herbert F., Camden *465
Johnson, V. Earl, Atlantic City *383
Judicial Councilors (See Councilors)

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book review
Annual Reports: May Journal
Official List: April Supplement
Transactions: August Supplement

K

Kalb, S. William, Newark *66
Kartagener Syndrome—Cohen, Goldstein and Hamill *557
Kenney, John A.† 297
Kessler, M. M., North Arlington *29
Kline, George L., Newark *486
Klosk, Emanuel, Newark *171
Knauer, Charles H.† 297
Knight, Richard† 34
Konzelmann, Frank W., Atlantic City *419
Kopetzky's Concept of Deafness, Tinnitus and Vertigo—Goldstein *27
Krakower, Alvin H., Paterson *72, *440

L

Ladies, To the 181
Lang, Joseph, Perth Amboy *112
Larkey, Irving G., Newark *322
Laryngotracheobronchitis, Acute (A. H. Neffson) br142
Lawrence, Elias D., Paterson *164
Law of Medicine (Callahan and Callahan) br406
Lay Laboratory and the Physician e411
Lee, Thomas B.† 571
Lens Extraction in Edentulous Patient—Snyder *289
Lewis, Robert L., Jr., Elizabeth *387
Libenson, Leon, Flemington *105
Liccese, Emanuel, Newark *519
Life Among the Doctors (DeKruif and De Kruif) br308
Light, Arthur B., Lawrenceville *276
London, William, Perth Amboy *415
Lower Nephron Nephrosis—Krakower and Gerson *72

M

MacFarland, Burr W.† 298
Malaria in Veterans 564
Malignancy in Gastric Ulcer — Perkel and Troast *521
Margins of Medicine e409
Marihuana in Latin America (P. Wolff) br142
Mass Chest X-ray—Willner *120
McCorkle, William E.† 447
McGeehan, Stanley M.† 340
Meckel's Diverticulum—Morton, Kline and Zuckerberg *486
Meckel's Diverticulum, Intestinal Obstruction in —Danzis *548
Medical Gynecology (J. C. Janney) br450
Medical Management of Gastro-intestinal Disorders (G. Cheney) br577
Medicine of the Year br493
Meinzer, Martin S.† 534
Melanomas, Present Aspects of—Goldberg *100
Members—
Official List of .....April Supplement
Supplementary Lists to the Official List:
No. 1 180
No. 2 254
No. 3 296
No. 4 349
No. 5 397
No. 6 489
No. 7 533
No. 8 571
Meningitis, Otogenic and Tuberculous—Steiner and Lang *112
Menopausal Symptoms Treated with Estrogens —Rommer *58
Mental Deficiency, Symposium on 445
Mental Health Programs of the Forty-eight States—Frankel *565
Merck Manual of Diagnosis and Therapy.....br577
Meurlin, Alfred, East Orange *318
Middlesex County Medical Society.....40, 88, 136, 302, 352, 400, 538
Minard, Edwy L.† 491
Miracle of Sudden Sight—Gurland *480
Mitchell, S. Weir (E. Earnest) br541
Mole, Hydatidiform—Grossbard *30
Monmouth County Medical Society.....40, 137, 302
Moolten, Sylvan E., Highland Park *517
Morris County Medical Society..40, 137, 302, 401, 574
Morrison, John B.† 85
Morrow, Roy, North Bergen *332
Morton, Thomas V., Jr., Newark *486
Multiple Myeloma — Bluefeld, Ringewald and Cheung *426
Murine Typhus in New Jersey—Weissberg and Herz *393
Myeloma, Multiple — Bluefeld, Ringewald and Cheung *426

N

Nabolotny, Tamara, Paterson *440
National Disability Insurance e147
National Science Foundation 266
Neonatal Deaths, Obstetrical Responsibility in —Meurlin *318
Nephrosis, Lower Nephron—Krakower and Gerson *72
Nervous Regulation of Intestinal Motility (W. B. Youmans) br347
Nevin, Richard I., Jersey City *313
New Jersey Medical Authors 129, 569
New Jersey Orthopaedic Society 539
New Jersey Plan e97, e99
New Jersey Proctologic Society 138
New Jersey Society of Physical Medicine 138, 342
New Jersey Specialty Societies 33
New Jersey Trudeau Society 21
Newman, Grace T., Montclair *279
Nichols, Stanley H.† o3, 34
Nicotinic Alcohol in Peripheral Vascular Disease—Brandman and Redisch *267
Nomenclature, Standard—Balk, Klosk and Bernstein *171

Normal Values in Clinical Medicine (F. W. Sunderman) br187
Norton, James F.† e1, e454, 571
—Resolution on Death of 527
Notkins, Meyer, Paterson *272

O

Obesity, Amphetamine Treatment—Kalb *66
Obituaries 34, 85, 130, 297, 340, 397, 447, 491, 534, 571
Obstetrical Anesthesia—Tuohy *514
Obstetrical Responsibility in Neonatal Deaths —Meurlin *318
Obstetrics and Diagnostic Gynecology, Handbook of (L. Doyle) br567
Occupational Dermatoses—Hanfling *379
Offenkrantz, Frederick M., Paterson *272
Officers, List of (Advertising page 3A each issue of The Journal)
Official List ....April Supplement
Ogden, Andrew E., Trenton *512
Older, Benjamin† 298
Operations of General Surgery (T. G. ORR)..br44
Operative Technic in Specialty Surgery (edited by W. H. Cole) br187
Oren, H., Park Ridge *524
Ophthalmology, Modern Practice in (edited by H. B. Stallard) br44

P

Parathion Poisoning 444
Parsonnet, Aaron E., Newark *504
Passaic County Medical Society....137, 303, 352, 539, 574
Pathology of Internal Diseases (W. Boyd)....br542
Pediatrics, Textbook of (edited by W. E. Nelson) br357
Peripheral Vascular Disease, Newer Therapeutic Agents in—Frank *9
Peripheral Vascular Disease, Nicotinic Alcohol in—Brandman and Redisch *267
Perkel, Louis L., Jersey City *521
Physiology of Heat Regulation (edited by L. H. Newburgh) br308
Physiology of Thought (H. Bailey) br358
Physiology, Textbook of (edited by J. F. Fulton) br357
Poliomyelitis, Management of—Light *276
Poliomyelitis, Recommended Practices for the Control of 126
Pons, C. A., Asbury Park *331
Pregnancy Complicated by Subarachnoid Hemorrhage—Gershenfeld and Savel *374
Pregnancy, Ectopic—Taber *464
Pregnenolone in Arthritis—Strazza *472
Prepatellar Bursa, Calcification of—Babbitt....*170
President's Message (Crowe)....e311, e409, e453, e497, e545
President's Message (Norton) e1
Price, H. Preston, Ridgewood *390
Privacy, Patients and Practitioners e362
Proctology in General Practice (J. P. Nesselrod) br542
Psychiatric Patients, Need for Improved Facilities for, in General Hospitals 127
Psychiatric Sections in General Hospitals (P. Haun) br450
Public Health News for the Physician....37, 86, 182, 299, 356, 398, 448, 492, 535
Public Health Statistics (M. F. Hall) br94
Pyloric Obstruction—Ogden *512

Q

Quinidine in Disorders of the Heart (H. Gold) br450

R

Radiologists Protest our Hospital Editorial.... 179
Rath, Charles K., Elizabeth *390
Ravdin, I. S., Philadelphia, Pa. *561
Rectal Bleeding, Significance of—Larkey....*322
Redisch, Walter, New York City....*267
Rehabilitation in Action—Gleason *270
Rehabilitation, Principles and Practices of (edited by H. H. Kessler)....br187
Removal of Intra-Ocular Foreign Bodies—Sherman *469
Reserve Medical Corps 528
Rheumatic Diseases, Cardiologic Aspects of—Dennison *4
Rhinitis, Operation for—Comora *369
Riese, Jacob A., West New York *388
Ringewald, Robert H., Englewood *426
Roberts, Joseph E., Jr.† 340
Robie, Theodore R., East Orange *370
Role of General Practitioner in 1950 Medicine —Horland *412
Role of the Gastroscopist in Diagnosis—Riese..*388
Rommer, J. J., South Orange *58
Rossell, Edward W.† 571
Rubber Bandage for Extremities—Schwartz...*526
Rubin, William, New Brunswick *68
Rupture of Tibilias Tendon—Strassburger....*281
Rupture of Uterus—Oren *524

S

Salem County Medical Society....89, 138, 303, 353, 575
Salt-Free Cook Book (E. Conason) br493
Sandler, Samuel A., Hackensack *49
Santangelo, Stephen† 447
Sarcoid Spleen with Purpura—Notkin, Offenkrantz and Abramo *272
Saslow, Benjamin, Newark *116
Savel, Lewis E., Newark *374
Schlossbach, Theo., Ocean Grove *166
Schnee, I. M., Paterson *124
Schneider, Charles, Honor to 181
Schneider, Harry M., Jersey City *161
Schwartz, Albert A., Perth Amboy *526
Scientific Sections Officers, List of (Advertising page 3A of May and July Journals)

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book review
Annual Reports: May Journal
Official List: April Supplement
Transactions: August Supplement

Sciorsci, Edward F., Hoboken *324
Scott, Norman M.† e146, 298
Medical-Surgical Plan Resolution 290
Trustees Resolution 348
Semantics of Cancer e98
Seton Hall Graduate Courses 487
Sex Without Fear (Lewin and Gilmour) br494
Sexual Deviations (London and Capiro) br577
Sexual Perversions, Meaning and Content of (M. Boss) br256
Shearer's Manual of Dissection (edited by C. E. Tobin) br93
Sherman, A. Russell, Newark *469
Shock Resulting from Burns 529
Simon, Franklin, Newark *504
Simplified Cord Tie—Krakower and Nabolotny *440
Skwirsky, Joseph, Newark *327
Slack, Clarence J.† 298
Smith, John V.† 491
Snyder, Howard P., Elizabeth *289
Society of Surgeons of New Jersey 353
Somerset County Medical Society 40, 89, 138, 303
Sommer, George N. J., Jr., Trenton *154
Speakers Bureau e499
Specialty Societies in New Jersey 33
Speech Problems of Children (edited by W. Johnson) br494
Spontaneous Rupture of the Heart—Rath and Price *390
Standard Nomenclature, Clinical Use of—Balk, Klosk and Bernstein *171
Steiner, Bela, Budapest, Hungary *112
Stomach, Cancer of—
Copleman *510
Perkel and Troast *521
Stomach, Surgical Lesions of—Ravdin *561
Stomatitis, Aphthous—Braitman *160
Strassburger, Paul, Belleville *281
Strazza, John A., Jr., Bloomfield *472
Streptomycin (edited by S. A. Waksman) br141
Supplements to THE JOURNAL—
Official List of Members April
Transactions August
Surgery, Monographs on (edited by B. N. Carter) br405
Surgical Lesions of Stomach—Ravdin *561
Surgical Treatment of Tuberculosis—Sommer *154
Sussex County Medical Society 575
Suture Material, Choice of—Hawkes *22
Synopsis of Hernia (A. H. Iason) br43

T

Taber, Frederick S., New Brunswick *464
Tarbell, Harold, Accolade to 275
Tausz, J. E., Newark *424
Tausz, Marta, Newark *424
Telangiectasia with Epistaxis—Gambacorta *61
Then Conquer We Must—Nevin *313
Therapeutic Exercises (H. Kraus) br94
They Gave of Themselves e48
This Last Best Chance on Earth—Chisholm *148
Thyroid, Malignancy of —Sclorsci *324
Tillis, Herman H., Newark *475
Todd, Francis H.† 130
Tomorrow's Medical Practice e546
Towards Effective Cancer Control e145
Trachea, Carcinoma of—Goldstein and Eisenstein *315
Tracheo-esophageal Anomaly in Siblings—Copleman, Cannata and London *415
Transactions August Supplement
Transactions Abstract 341
Trichinosis with Heart Involvement — Goldberg and Biber *152
Troast, Leonard, Jersey City *521
Tropical Disease Abstracts 445
Trustees, Board of—
Election of Chairman and Secretary 346
List of (Advertising page 3A, each issue of THE JOURNAL)
Meetings:
December 18, 1949 32
January 15, 1950 81
February 19, 1950 175
April 16, 1950 343
May 21, 1950 344
May 24, 1950 345
October 1, 1950 531
November 12, 1950 568
Tuberculosis Abstracts 45, 95, 143, 189, 257, 309, 359, 407, 451, 495, 543, 591
Tuberculosis, Surgical Treatment of—Sommer *154
Tumen, Henry J., Philadelphia *455
Tumors, Cerebral, in Children—Sandler *49
Tunis, Benno, Newark *483
Tuohy, Edward B., Washington, D. C. *514
Turased in Hypertension — Parsonnet, Simon and Bernstein *504
Two-Layer Lateral Anastomosis—Evans *56
Typhoid Fever Treated with Chloromycetin—Gleason and Goldstein *416
Typhus in New Jersey—Weissberg and Herz *393

U

Union County Medical Society 89, 184, 353, 401, 539
Urinary Function of the Kidney (A. V. Wolf) br586
Uterine Cervix, Carcinoma of—(H. Wespi) br357
Uterine Suspension—Baker *123
Uterus, Rupture of—Oren *524

V

Van Sciver, John E. L.† 447
Vertigo—Brunner *375
Vertigo, Kopetzky's Concept of—Goldstein *27
Views and Reviews 35, 131

W

Wade, Simon F.† 534
Warren County Medical Society 575
Warren, David E.† 534
We Must Fight On—Allman *442
Weissberg, William W., Elizabeth *393

Welfare Committee e453, 530
History of 488
Welkind, Allen, Newark *501
Why Medical Economics?—Dickinson *262
Why Not X-ray Before Marriage?—Craster....*395
Willner, Irving, Newark *120
Wittenborn, William F. J., Trenton *105
Woman's Auxiliary—
Acceptance of the Gavel 304
Allman, Mrs. David B., Tribute to 402
Atlantic County 41, 91, 139, 185, 305, 355, 576
Bergen County 305, 355, 540, 576
Bulletin, Case Report of the 449
Camden County 140, 305, 355, 540
Cape May County 540
Casselman, Mrs. Arthur Jay 90
Convention Meetings 402
Cottone, Mrs. R. J. 304, 449, 576
Essex County.....42, 140, 186, 404, 541
Executive Board Meetings.....91, 185, 540
Governor Speaks at Health Conference..... 354
Hudson County.....42, 91, 140, 186, 306
Little Boy Blue 139
Nathanson, Mrs. Norman 41, 139
Passaic County 541
President's Message (Cottone) 449, 576
President's Message (Nathanson) 41
Public Relations Conference 185
Somerset County 42, 306
South Jersey Woman of the Year 90
Union County 186
Warren County 186

X

X-ray, Premarital—Craster *395

Y

Yates, John S.† 298
Year of Ultimate Decision e1
You and Your Heart (H. M. Marvin et al.)....br586

Z

Zuckerberg, Nathan, Newark *486

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book review
Annual Reports: May Journal
Official List: April Supplement
Transactions: August Supplement

BOOK REVIEWS

You and Your Heart. By H. M. Marvin, M.D., T. Duckett Jones, M.D., Irvine H. Page, M.D., Irving S. Wright, M.D., and David D. Rutstein, M.D. Pp. 306. New York, 1950, Random House. ($3.00)

This is a guide for intelligent laymen who want to know about the normal and the diseased heart. Five outstanding specialists have joined to write a book that gives a sense of the magnitude of the problem of heart disease and how the medical profession is trying to cope with it. In logical sequence the reader is introduced first to the anatomy and physiology of the normal heart. Then he traces the gradual accumulation of medical knowledge in an historical review, and finally learns of the various tools used in cardiology, the sphygmomanometer, the electrocardiograph, and the fluoroscope.

The second section of the book is a non-technical discussion of specific diseases such as congenital defects, hypertension, et cetera. Emphasis is constantly placed on understanding the changes that take place so as to enable the patient to cooperate best with the physician. The authors scrupulously avoid any information that would encourage self-diagnosis, or self-medication. A valuable chapter by Dr. Marvin discusses common fallacies about heart disease and explains why they are wrong.

This is not an easy book for the average layman to read. Since the authors have shunned the glib and dramatic approach, their text may be inacceptable to those who demand easy and obvious answers. But to the sincerely interested and moderately intelligent person, this highly informative book will be of real service in lessening the terror of those mysterious words, "a heart condition".

Marvin Shapiro, M.D.

Freud: Dictionary of Psycho-Analysis. Nandor Fodor and Frank Gaynor. New York, Philosophical Library, 1950. Pp. 208. ($3.75)

Psycho-analysts often disagree among themselves as to what the Founder really meant by some of his terms. This gives this current volume a unique place in lexicographic history. In alphabetical order, from abasia to zoophobia, the editors have selected significant phrases and quoted *verbatim* from Freud to show what he meant by the terms. Sometimes words are formally defined. More often their meaning is indicated by the context of their use. The *Dictionary* is a useful accessory volume in the library of any psycho-analyst. Since it cannot stand by itself as a text in psycho-analysis, it has much less value to the non-analyst.

Julius Sobin, M.D.

The Urinary Function of the Kidney. By A. V. Wolf, Ph.D. (Pp. 363.) New York, Grune & Stratton, Inc., 1950. ($7.50)

This is a very detailed and complicated treatise on the physiology of the kidney and related fields and of value only to the investigator. The author clarifies such intricate subjects as the regulation of body volumes as compared to body concentrations; the absolute and relative dehydration and hydration; the endocrine relationships to urine volume and composition. A clear concept of the factors in edema and the physiology involved is presented.

Adequate interpretation of much of the text is difficult and the work has little value for the clinician. For the investigator the bibliography of more than a thousand references enhances its research significance.

Irving Maisel, M.D.

Additional Book Reviews on pages 567 and 577.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIII **December, 1950** **No. 12**

THE NUMBER of cases of unsuspected tuberculosis in the general population would be greatly reduced if physicians would require chest X-rays as a part of the routine examination of all private patients. Now as always, the physician in private practice is a key figure in the control of tuberculosis.

CASE FINDING AMONG PRIVATE PATIENTS

It is recognized that there are many reasons for the rapid decline in the incidence of tuberculosis during the past 50 years. It is impossible to evaluate accurately, or even approximately, the relative influence of complex socioeconomic conditions and of control measures in bringing about this favorable result.

In 1937, Wade H. Frost concluded that the point had been reached in the United States where there is a gradual downward trend in the incidence of tuberculosis, and that, barring major upsets in civilization, the eventual eradication of the disease can be expected. The continued decline in the annual number of deaths from tuberculosis during the past 12 years, in spite of the adverse conditions caused by a great war, is ground for confidence in the accuracy of Frost's conclusion.

Even though control measures are only one factor in the eradication of tuberculosis, they may very well be the decisive factor. Anything which will reduce the size of the reservoir of the tubercle bacillus in human beings will lessen the number of new cases of tuberculosis. Every case of the disease, actually or potentially infectious, which is discovered and brought under control is a step in reducing the size of this reservoir. In the aggregate, control measures may represent the weight which will tip the balance in favor of the human race. It is this consideration which gives importance to any method which discloses a considerable number of cases of tuberculosis, and especially of those which are symptomless.

Although statements to the contrary have been made recently, nothing is more completely proved than the fact that approximately one-half of all cases of significant tuberculosis have no symptoms, or symptoms so slight as to escape notice. According to the National Tuberculosis Association estimates, there are a quarter of a million unknown cases of tuberculosis in the United States—at least as many as there are known cases—and recent experience indicates that the unknown cases far outnumber the known. In the 1948 mass survey in Washington, D. C., 4098 out of 4665 cases of tuberculosis discovered were previously unknown to the health department. Similar findings have been reported in all other large surveys.

From its small beginnings during the decade 1930-40, the mass survey method for tuberculosis detection has advanced in the United States to the point where at present about 14 million people annually undergo chest X-ray examinations. This is a significant achievement, and although it can be extended until the equipment already existing is fully utilized, it still does not represent a case-finding rate sufficiently high to insure control of the disease in any reasonable time. It is important that the mass survey programs be enlarged, but, in the meantime, every method which promises disclosure of a considerable number of cases of tuberculosis should be utilized.

Sixty to eighty million Americans, for one reason or another, annually consult a doctor, and it is known that the tuberculosis rate among them is much higher than among the general population. For this reason it is highly desirable that private physicians, including general practitioners, internists, and specialists, obtain a survey film of every patient who consults them unless the results of a recent chest X-ray survey are available.

It has been the practice of some radiologists for many years to make a single film of the chest in cases referred for other examinations, especially in cases referred for gastro-intestinal study. This has

disclosed many unsuspected chest conditions including tuberculosis. Now that photofluorography has greatly reduced the cost of such a survey film it should become routine practice among radiologists; its quite nominal cost can be absorbed in the major examination.

This reservoir of cases, however, is small compared with the vast number who consult general practitioners and internists. Methods can undoubtedly be devised whereby all such patients, at least those who are 15 years of age or older, can have a survey film made without cost to the patient—even a small charge would probably prevent wide use of the method. It is not necessary that any one method be adopted to accomplish the desired end. In some communities, the local or state health department could, perhaps, defray the cost as part of the general tuberculosis prevention program, especially in view of the fact that case finding in the smaller group would be relatively much more productive than in the usual mass survey. In other communities, it could be done by the tuberculosis association. In still others, general hospitals which have adopted a hospital admission X-ray survey program could enlarge the program to include survey films for the private patients of members of the hospital staff. Furthermore, it could very well become general practice among radiologists to make available such service to the general profession.

The details of such a program may seem numerous and difficult at first thought, but they can be worked out. The first essential for its success is the interest of the private physicians of each community. They are in the best position to promote it and to carry it out.

Today, because of procedures which have become routine, the private physician's office is a bulwark against such diseases as smallpox and diphtheria. In like manner, it can become one of the most effective agencies for tuberculosis control. By promoting such a public health measure, the general practitioners of the nation would be acting in line with the great tradition of the profession as a force for prevention as well as cure of disease.

Case Finding Among Private Patients, A. C. Christie, M.D., Pub. Health Rep., June 2, 1950.

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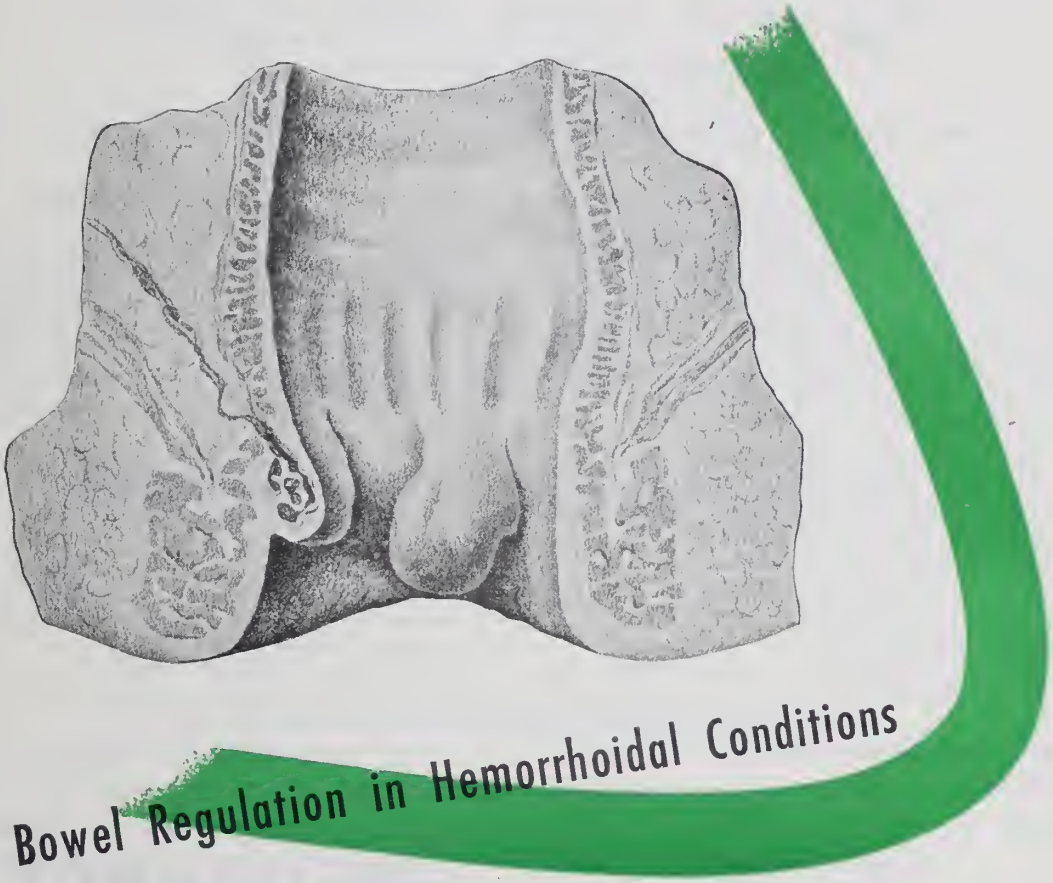

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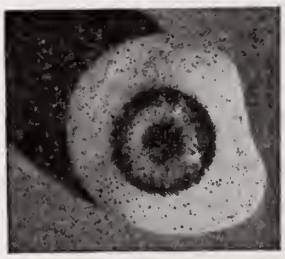

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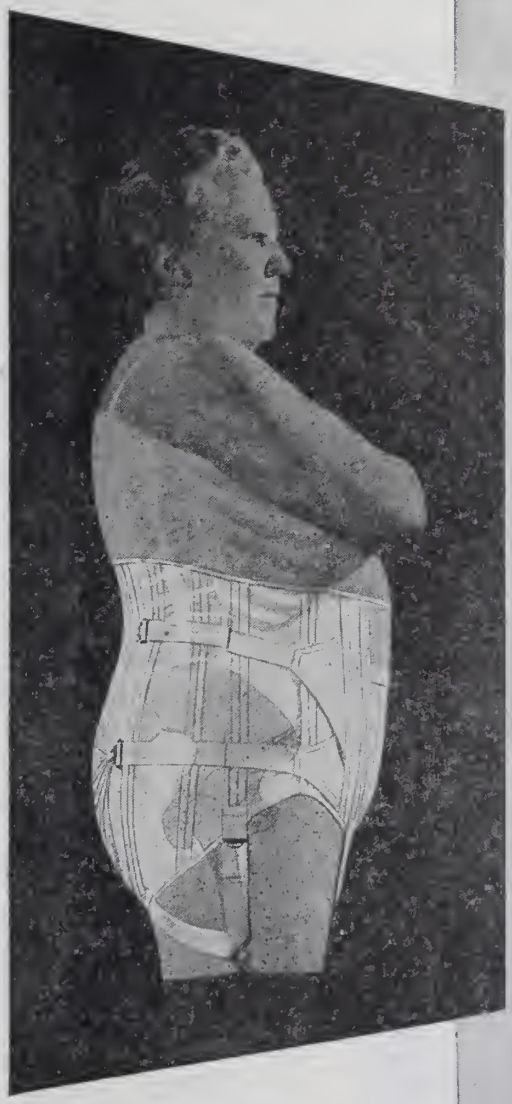

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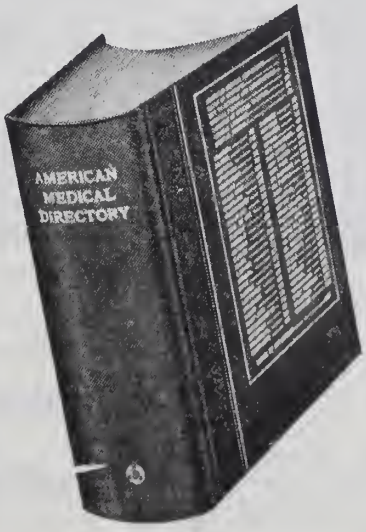

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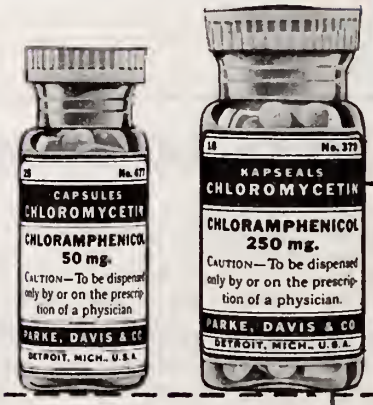

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Bibliography

1. Hewitt, W. L., and Williams, Jr., B.: New England J. Med. *242*:119, 1950.
2. Recinos, Jr., A.; Ross, S.; Olshaker, B., and Twible, E.: New England J. Med. *241*:733, 1949.
3. Wood, E. J.: Lancet 2:55, 1949.

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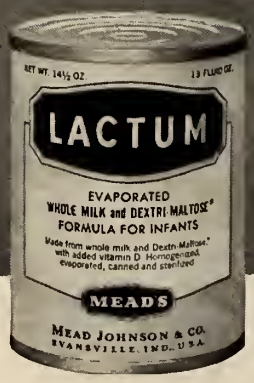

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Official List--March 1, 1950

OF

FELLOWS AND MEMBERS

Supplement to The Journal of The Medical Society of New Jersey, April, 1950

The Medical Society of New Jersey

OFFICIAL LIST—MARCH 1, 1950

of

FELLOWS AND MEMBERS

CONTENTS

Page

FELLOWS 2

HONORARY MEMBERS 4

EMERITUS MEMBERS 4

MEMBERSHIP SUMMARY 4

COUNTY LISTING:

- Atlantic 5
- Bergen 6
- Burlington 9
- Camden 10
- Cape May 12
- Cumberland 12
- Essex 13
- Gloucester 23
- Hudson 23
- Hunterdon 26
- Mercer 27
- Middlesex 29
- Monmouth 30
- Morris 32
- Ocean 33
- Passaic 34
- Salem 37
- Somerset 38
- Sussex 38
- Union 39
- Warren 42

ALPHABETICAL LISTING 43

OFFICIAL LIST OF MEMBERS
OF
THE MEDICAL SOCIETY OF NEW JERSEY
FOR THE YEAR 1950

FELLOWS

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Article IV, Section 2-a)

Year of Election

1. 1766—Robert McKean, Perth Amboy, 1732-1767
2. 1767—William Burnet, Newark, 1730-1791
3. 1768—John Cochran, New Brunswick, 1730-1807
   1769—John Cochran, No. 3, reëlected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781
5. 1771—Isaac Smith, Trenton, 1740-1807
6. 1772—James Newell, Freehold, 1725-1791
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807
8. 1774—Thomas Wiggins, Princeton, 1731-1801
9. 1775—Hezekiah Stites, Cranbury, 1726-1790

No formal meetings 1776-1780 on account of the War of the Revolution.

   1781—James Newell, No. 6, reëlected
10. 1782—John Beatty, Trenton, 1749-1826
11. 1783—Thomas Barber, Matawan, 1730-1807
12. 1784—Lawrence Vander Veer, Roycefield, 1740-1815
13. 1785—Moses Bloomfield, Woodbridge, 1729-1791
    1786—William Burnet, No. 2, reëlected
14. 1787—Jonathan Elmer, Bridgeton, 1745-1817
15. 1788—James Stratton, Swedesboro, 1755-1812
16. 1789—Moses Scott, New Brunswick, 1738-1821
17. 1790—John Griffith, Rahway, 1736-1805
18. 1791—Lewis Dunham, New Brunswick, 1754-1821
19. 1792—Isaac Harris, Middlesex County, 1741-1808

No elections held in 1793 and 1794 because quorum not present.

20. 1795—Elisha Newell, Allentown, 1755-1799

No formal meetings 1796-1806 owing to an attempt to establish a rival society in Eastern New Jersey.

21. 1807—Jonathan F. Morris, Somerville, 1760-1810
22. 1808—Peter I. Stryker, Somerville, 1766-1859
23. 1809—Lewis Morgan, Rahway, 1757-1821
24. 1810—Lewis Condict, Morristown, 1773-1862
25. 1811—Charles Smith, New Brunswick, 1768-1848
26. 1812—Matthias H. Williamson, Elizabeth
    1813—Matthias H. Williamson, continued for second year
27. 1814—Samuel Forman, Freehold, 1764-1845
28. 1815—John Van Cleve, Princeton, 1778-1826
    1816—Lewis Dunham, No. 18, reëlected
    1817—Peter I. Stryker, No. 22, reëlected
    1818—John Van Cleve, No. 28, reëlected
    1819—Lewis Condict, No. 24, reëlected
29. 1820—James Lee, Newark
30. 1821—William G. Reynolds, Manalapan

Year of Election

31. 1822—Augustus R. Taylor, Somerville, 1782-1840
32. 1823—William B. Ewing, Greenwich, 1776-1866
    1824—Peter I. Stryker, reëlected. Also served 1808 and 1817.
33. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
34. 1826—William D. McKissack, Millstone, 1781-1853
35. 1827—Isaac Pierson, Orange, 1770-1833
36. 1828—Jephtha B. Munn, Chatham, 1780-1863
37. 1829—John W. Craig, Somerset County, 1795-1871
    1830—Augustus R. Taylor, No. 31, reëlected
38. 1831—Thomas Yarrow, Sharptown, 1778-1841
39. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
40. 1833—William Forman, Monmouth County, 1796-1848
41. 1834—Samuel Hayes, Newark, 1776-1839
42. 1835—Abraham P. Hagerman, Somerset County
43. 1836—Henry Vander Veer, Somerville, 1792-1874
44. 1837—Lyndon A. Smith, Newark, 1795-1865
45. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
46. 1839—Jabez G. Goble, Newark, 1799-1859
47. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
48. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
49. 1842—Zachariah Read, Mt. Holly, 1808-1879
50. 1843—Abraham Skillman, Bound Brook, 1796-1862
51. 1844—George R. Chetwood, Elizabeth, 1802-1885
52. 1845—Robert S. Smith, Bound Brook, 1800-1874
53. 1846—Charles Hannah, Deerfield, 1782-1857
54. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
55. 1848—Samuel Hayes Pennington, Newark, 1806-1900
56. 1849—Joseph Fithian, Woodbury, 1795-1881
57. 1850—Elias J. Marsh, Paterson, 1803-1850
58. 1851—John H. Phillips, Pennington, 1814-1878
59. 1852—Othneil H. Taylor, Camden, 1803-1869
60. 1853—Samuel Lilly, Lambertville, 1815-1880
61. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
62. 1855—James B. Coleman, Trenton, 1806-1877
63. 1856—Richard M. Cooper, Camden, 1816-1874
64. 1857—Thomas Ryerson, Newton, 1821-1887
65. 1858—Isaac Pierson Coleman, Pemberton, 1804-1869
66. 1859—John R. Sickler, Mantua, 1800-1886
67. 1860—William Elmer, Bridgeton, 1814-1889

Year of Election

68. 1861—John Blane, Perryville, 1802-1885
69. 1862—John Woolverton, Trenton, 1825-1888
70. 1863—Theodore R. Varick, Jersey City, 1825-1887
71. 1864—Ezra M. Hunt, Metuchen, 1830-1894
72. 1865—Abraham Coles, Newark, 1813-1891
73. 1866—Benjamin R. Bateman, Bridgeton, 1807-1883
74. 1867—John C. Johnson, Blairstown, 1828-1907
75. 1868—Thomas J. Corson, Trenton, 1828-1879
76. 1869—William Pierson, Orange, 1796-1882
77. 1870—Thomas F. Cullen, Camden, 1822-1877
78. 1871—Charles Hasbrouck, Hackensack, 1818-1877
79. 1872—Franklin Gauntt, Burlington, 1823-1900
80. 1873—Thomas J. Thomason, Perrineville, 1833-1880
81. 1874—George H. Larison, Lambertville, 1831-1892
82. 1875—William O'Gorman, Newark, 1824-1887
83. 1876—John V. Schenck, Camden, 1825-1882
84. 1877—Henry R. Baldwin, New Brunswick, 1829-1902
85. 1878—John S. Cook, Hackettstown, 1827-1900
86. 1879—Alexander W. Rogers, Paterson, 1814-1905
87. 1880—Alexander N. Dougherty, Newark, 1822-1882
88. 1881—Lewis W. Oakley, Elizabeth, 1828-1888
89. 1882—John W. Snowden, Blackwood, 1823-1888
90. 1883—Stephen Wickes, Orange, 1813-1889
91. 1884—Phanett C. Barker, Morristown, 1835-1903
92. 1885—Joseph Parrish, Burlington, 1818-1891
93. 1886—Charles J. Kipp, Newark, 1838-1911
94. 1887—John W. Ward, Trenton, 1840-1916
95. 1888—H. Genet Taylor, Camden, 1837-1916
96. 1889—Beriah A. Watson, Jersey City, 1836-1892
97. 1890—James S. Green, Elizabeth, 1829-1892
98. 1891—Elias J. Marsh, Paterson, 1835-1908
99. 1892—George T. Welch, Passaic, 1845-1924
100. 1893—John G. Ryerson, Boonton, 1834-1916
101. 1894—Obadiah H. Sproul, Flemington, 1844-1925
102. 1895—William Elmer, Trenton, 1840-1908
103. 1896—Thomas J. Smith, Bridgeton, 1841-1932
104. 1897—David C. English, New Brunswick, 1842-1924
105. 1898—Claudius R. P. Fisher, Bound Brook, 1859-1927
106. 1899—Luther M. Halsey, Williamstown, 1858-1921
107. 1900—William Pierson, Jr., Orange, 1830-1900
108. 1901—John D. McGill, Jersey City, 1846-1912
109. 1902—Edward L. B. Godfrey, Camden, 1850-1913
110. 1903—Henry Mitchell, Asbury Park, 1845-1919
111. 1904—Walter B. Johnson, Paterson, 1852-1922
112. 1905—Henry W. Elmer, Bridgeton, 1847-1907
113. 1906—Alexander Marcy, Jr., Riverton, 1860-1934
114. 1907—Edward J. Ill, Newark, 1854-1942
115. 1908—David St. John, Hackensack, 1850-1917
116. 1909—Benjamin A. Waddington, Salem, 1842-1917

Year of Election

117. 1910—Thomas H. MacKenzie, Trenton, 1847-1920
118. 1911—David Strock, Camden, 1850-1927
119. 1912—Norton L. Wilson, Elizabeth, 1861-1931
120. 1913—Enoch Hollingshead, Pemberton, 1843-1924
121. 1914—Frank D. Gray, Jersey City, 1857-1916
122. 1915—William J. Chandler, South Orange, 1842-1927
123. 1916—Philip Marvel, Atlantic City, 1856-1938
124. 1917—William G. Schauffler, Lakewood, 1862-1933
125. 1918—Thomas W. Harvey, Orange, 1853-1938
126. 1919—Gordon K. Dickinson, Jersey City, 1855-1930
127. 1920—Philander A. Harris, Paterson, 1852-1924
128. 1921—Henry B. Costill, Trenton, 1860-1935
129. 1922—James Hunter, Jr., Westville, 1866-1931
130. 1923—Wells P. Eagleton, Newark, 1865-1946.
131. 1924—Archibald Mercer, Newark, 1849-1931. Resigned.
1924—**LUCIUS F. DONOHOE**, Acting President
132. 1925—**LUCIUS F. DONOHOE**, Bayonne, born 1868
133. 1926—James S. Green, Jr., Elizabeth, 1864-1936
134. 1927—Walt P. Conaway, Atlantic City, 1873-1945
135. 1928—Ephraim R. Mulford, Burlington 1880-1939
136. 1929—Andrew F. McBride, Paterson, 1869-1946
137. 1930—**GEORGE N. J. SOMMER**, Trenton, born 1874
138. 1931—John F. Hagerty, Newark, 1869-1937
139. 1932—A. Haines Lippincott, Camden, 1867-1937
140. 1933—**FREDERIC J. QUIGLEY**, Jersey City. born 1883
141. 1934—**LANCELOT ELY**, Somerville, born 1875
142. 1935—**MARCUS W. NEWCOMB**, Browns Mills, born 1880
143. 1936—Francis R. Haussling, Newark, 1875-1941 —resigned
144. 1936—**SPENCER T. SNEDECOR**, Hackensack, born 1900
145. 1937—**WILLIAM G. HERRMAN**, Asbury Park, born 1890
146. 1938—William J. Carrington, Atlantic City, 1884-1947
147. 1939—**E. ZEH HAWKES**, Newark, born 1865
148. 1940—**WATSON B. MORRIS**, Springfield, born 1878
149. 1941—Thomas K. Lewis, Camden, 1887-1949.
150. 1942—Ellas J. Marsh, Paterson, 1875-1943
151. 1943—**RALPH K. HOLLINSHED**, Westville, born 1884
152. 1944—**JOSEPH F. LONDRIGAN**, Hoboken, born 1884
153. 1945—**SAMUEL ALEXANDER**, Park Ridge, born 1888
154. 1946—Frank G. Scammell, Trenton, 1877-1947.
155. 1947—**ROYAL A. SCHAAF**, Newark, born 1892.
156. 1948—**J. HOWARD HORNBERGER**, Roebling, born 1896
157. 1949—**JAMES F. NORTON**, Jersey City, born 1892

The names of living Fellows are in bold face type.

HONORARY MEMBERS

Year of Election

1. 1930—Joseph E. Raycroft, Princeton
2. 1939—Nathan B. Van Etten, New York
3. 1939—Haven Emerson, New York
4. 1945—Lucius F. Donohoe, Bayonne
5. 1947—Mr. John S. Thompson, Glen Ridge
6. 1948—Mr. William H. MacDonald, Trenton
7. —Mr. George E. Stringfellow, Glen Ridge

EMERITUS MEMBERS

Year of Election

1949—Areson, William H., Ontario, Canada
1948—Atwell, David R., East Orange
1949—Baird, Thompson M., Point Pleasant
1949—Bleick, Theodore E., Newark
1949—Carman, Fletcher F., Montclair
1949—Chamberlain, Aims R., Maplewood
1949—Cogan, Henry, Daytona Beach, Fla.
1948—Connell, John, Jersey City
1949—Conroy, John S., Burlington
1949—Darlington, Emlen P., New Lisbon
1949—Davison, Royden W., Miami, Fla.
1949—Eaton, Arthur T., Haddon Heights
1949—Emerson, Linn, Orange
1949—Fell, Alton S., Trenton
1948—Flitcroft, William, Waukesha, Wisc.
1949—Foster, Herbert W., Montclair
1948—Gille, Hugo, Jersey City
1949—Guidi, Guido M., Elizabeth
1949—Harman, William J., Trenton
1949—Hughes, Frederic J., San Mateo, Cal.
1949—Hunter, Edward R., Delanco
1948—Keegan, Thomas D., Deal
1949—Lawrence, William H., DeLand, Fla.
1949—Lovett, Joseph C., Ardsley, Pa.
1949—Lowy, Otto, West Orange
1949—Mendenhall, Clinton D., Bordentown

Year of Election

1949—Metzer, Emma P. W., Riverside
1949—Mierau, Ernest W., W. Point Pleasant
1948—Older, Benjamin, St. Petersburg, Fla.
1949—Orton, George L., Rahway
1949—Price, Nathaniel G., Sarasota, Fla.
1949—Ranson, Briscoe B., Jr., East Orange
1949—Richardson, Emma M., Camden
1949—Ritter, John J., Plainfield, Mass.
1948—Rosecrans, James H., Hoboken
1949—Rossell, Edward W., Colwick
1949—Schachter, Harry A. H., Deal
1949—Scribner, Charles H., Paterson
1948—Selinger, Samuel, Lake Worth, Fla.
1948—Sexsmith, George H., Los Angeles, Calif.
1949—Sill, John B., Seaside Park
1949—Simkins, Raymond, Bridgeton
1949—Smith, Byron J., East Orange
1949—Smith, Joseph J., Newark
1948—Stout, J. Phillip, Red Bank
1949—Szerlip, Leopold, Newark
1949—Teeter, Charles E., Newark
1949—Tidaback, John D., Summit
1949—Timlin, James W., Arlington
1949—Turner, Irvine F. P., Titusville
1949—Van Sciver, John E. L., Haddonfield
1949—Wade, Simon F., Milford, Pa.
1948—Woelfle, Henry E., East Orange

MEMBERSHIP SUMMARY

	Active	*Associate*
Atlantic	149	23
Bergen	365	24
Burlington	51	
Camden	251	
Cape May	32	
Cumberland	70	
Essex	1307	35
Gloucester	44	
Hudson	441	
Hunterdon	26	
Mercer	253	19
Middlesex	202	10
Monmouth	177	22
Morris	129	
Ocean	32	
Passaic	454	26
Salem	34	
Somerset	70	
Sussex	33	
Union	435	
Warren	35	
	4590	159

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

MARCH 1, 1950

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Allar, Ellis H., 115 St. Charles pl., Atlantic City
Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Axilrod, Maurice H., 2620 Pacific av., Atlantic City
Baldwin, Charles H., 2829 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic City
Bayer, Harold J., 1616 Pacific av., Atlantic City
Beir, Ily R., 3900 Atlantic av., Atlantic City
Bew, David F., 7500 Ventnor av., Margate City
Bew, Richard C., 1217 Pacific av., Atlantic City
Bradley, Robert A., 1616 Pacific av., Atlantic City
Brown, Francis S., 2216 Shore rd., Northfield
Brown, J. Carlisle, 1616 Pacific av., Atlantic City
Cameron, Joseph H., 720 Shore rd., Somers Point
Charlton, C. Coulter, 1616 Pacific av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., AtlanticC'y
Cleary, Joseph P., Minotola
Collins, John F., 1208 Columbia av., Pleasantville
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Cutler, Milton, 554 Bellevue av., Hammonton
Dalton, S. Eugene, 101 S. Surrey av., Ventnor
Davidson, Harold S., 117 S. Illinois av., Atlantic City
deHellebranth, Roland T., 104 S. Fr'nkf't av.,Ventn'r
Dierwechter, Reuben, 12 N. Providence av., Atl. City
DiNicolantonio, Vincent J., 3121 Atlantic av., Atl. C'y
Dintenfass, Arthur, 1616 Pacific av., Atlantic City
Diskan, Samuel M., 1616 Pacific av., Atlantic City
Durham, Robert B., 110 S. North Carolina av., Atl. C.
Durham, Royal E., 100 S. New Haven av., Ventnor
Dyer, Edward H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 11532 Dilling st., N. Hollyw'd,Cal.
Ellenbogen, Leonard S., 1616 Pacific av.,Atl'nticCity
Elliott, Frazier J., 10 N. Second st., Hammonton
Erber, Leonard B., 1902 Pacific av., Atlantic City
Ernst, Philip A., 16 E. Main st., Mays Landing
Esposito, Antonio L., 31 12th st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Philadelphia av., Egg Harbor
Frank, Perry, 227 Philadelphia av., Egg Harbor
Gleason, James F., 5407 Atlantic av., Ventnor
Goldman, Louis C., 6 N. Austin av., Ventnor
Goldstein, Samuel, 34 E. Main st., Mays Landing
Goodman, Harry P., 101 S. Indiana av., Atlantic City
Gordon, Benjamin L., 6917 Atlantic av., Ventnor
Gordon, Maurice B., 6917 Atlantic av., Ventnor
Gorson, Samuel F., 2005 Pacific av., Atlantic City
Gottlieb, Morris, 1616 Pacific av., Atlantic City
Green, Martin, 1922 Pacific av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pleasantville
Gross, Max, 7401 Atlantic av., Margate City
Gruhler, Jean A., 1616 Pacific av., Atlantic City
Guion, Edward, 1219 S. Main st., Pleasantville
Halpern, Samuel, 7405 Ventnor av., Margate City
Hamburger, Werner, 1616 Pacific av., Atlantic City
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harley, Robison D., 101 S. Indiana av., Atlantic City
Harris, William O., 32 N. New Jersey av., Atl. City
Hersohn, William W., 14 N. Rumson av., Margate C.
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 15 N. Indiana av., Atlantic City
Holoman, M. Browne, 1 N. Haverford av., Marg'te C.
Hyman, Charles, 2807 Pacific av., Atlantic City
Infield, Gerald L., 707 Shore rd., Northfield
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaman, Samuel L., 1616 Pacific av., Atlantic City
Kearney, Hugh, 323 North Main st., Pleasantville
Kline, Herman, 2643 Pacific av., Atlantic City
Konzelmann, Frank W., 304 S. Shore rd., Absecon
Krechmer, Abraham, 400 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Leonard, Isaac E., Jr., 2842 Atlantic av., AtlanticC'y
Lippman, Nathan L., 504 Pacific av., Atlantic City
Lucas, Stanley L., 44 N. Kentucky av., Atlantic City
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4212 Ventnor av., Atlantic City
Marshall, H. Donald, 707 N. Indiana av., AtlanticC'y
Marvel, Peter H., 2216 Shore rd., Northfield
Mason, James H., 1616 Pacific av., Atlantic City
McCracken, Josiah C., Jr., 16 S. Suffolk av., Ventnor
McGahn, Joseph, 18 S. Stenton pl., Atlantic City
McGeehan, Stanley M., 6505 Atlantic av., Ventnor
Merendino, Anthony G., 1616 Pacific av., AtlanticC'y
Milano, Cesare A., 1 S. Brighton av., Atlantic City
Mishler, Jay E., 1616 Pacific av., Atlantic City
Molitch, Matthew, 705 Pacific av., Atlantic City
Murray, Clifford K., 5901 Ventnor av., Ventnor
Naame, John M., 8014 Monmouth av., Margate City
Nickman, E. Harrison, 1616 Pacific av., Atlantic C'y
Pastore, Mario, 1925 Pacific av., Atlantic City
Paul, Abraham, 4901 Atlantic av., Ventnor
Pennington, John, 101 S. Indiana av., Atlantic City
Perez, John F., 3403 Pacific av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City
Powell, Robert J., 410 N. Ohio av., Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor
Reinhard, Louis, 2627 Pacific av., Atlantic City
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Richardson, Jefferson N., 101 S. Indiana av., Atl.City

Rieck, Allan, 507 S. Shore rd., Pleasantville
Rise, Wilson S., 1616 Pacific av., Atlantic City
Ritter, Morton D., 1616 Pacific av., Atlantic City
Rodi, Louis M., 412 Bellevue av., Hammonton
Roop, William O., 522 S. Shore rd., Absecon
Rosenberg, Louis, 1616 Pacific av., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Rubba, Russell R., 21 Horton st., Hammonton
Ruby, Victor M., 325 Atlantic av., Atlantic City
Salasin, Samuel L., 511 Pacific av., Atlantic City
Saseen, Charles A., 60 S. Delancey pl., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Scanlan, David B., 1 S. Oxford av., Atlantic City
Schwarzkopf, George C., 2901 Pacific av., AtlanticC'y
Scott, Joseph H., 129 N. Pennsylvania av., Atl. City
Shavelson, Irving C., 1616 Pacific av., Atlantic City
Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City
Shuster, Samuel A., 405 Pacific av., Atlantic City
Sinderbrand, Robert E., 344 Phila. av., Egg Harbor
Sinkinson, Chas. D., Jr., 1616 Pacific av., AtlanticC'y
Stamps, G. Ruffin, 1616 Pacific av., Atlantic City
Stewart, Sloan G., 43 S. North Carolina av., Atl. City
Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, 2 S. Somerset av., Ventnor
Surran, Carl A., 1616 Pacific av., Atlantic City
Targan, Nathan, 27 N. Connecticut av., Atlantic City
Timberlake, Baxter H., 5414 Ventnor av., Ventnor
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Vandenberg, Werner, 7 S. La Clede pl., Atlantic City
Volpe, Donald J., 503 Central av., Hammonton
Walker, Levi M., 5407 Atlantic av., Ventnor
Weeks, Belford A., 534 South Shore rd., Absecon
Weiner, Samuel E., 904 Pacific av., Atlantic City
Weintrob, Joseph R., 1616 Pacific av., Atlantic City
Westney, F. Rolfe, 7602 Ventnor av., Ventnor
Whims, Clarence B., 5407 Atlantic av., Ventnor
White, R. Rostin, 644 Shore rd., Somers Point
Williams, Raymond A., 7207 Atlantic av., Ventnor
Wilner, Daniel, 5407 Atlantic av., Ventnor
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City
Woolbert, Edwin, 15 W. Washington av., Pleas'tv'le

ASSOCIATE MEMBERS

Bowen, John R., Jr., 1036 Maple av., Linwood
Burkhardt, Hans E., 1616 Pacific av., Atlantic City
Cutler, Paul, 1616 Pacific av., Atlantic City
Doggett, Frank B., Jr., 124 North Ohio av., Atl. City
Holland, John W., 4 So. Haverford av.. Margate City
Leach, Morton W., 1616 Pacific av., Atlantic City
Mason, James H., IV, 52 Revere rd., Drexel Hill, Pa.
Mattioli, Eli D., Harding Highway, Landisville
Rosen, Samuel C., 1329 Pacific av., Atlantic City
Ruppert, Ralph E., 1517 North Ohio av., Atlantic C.
Southard, Samuel C., 112 St. Davids pl., Atlantic C.
Ware, Charles I., 174 North Main st., Pleasantville

COURTESY MEMBERS

Barab, Barney M., D.D.S., Atlantic City
Berger, A. E., D.C., Atlantic City
Jonas, Charles S., D.D.S., Atlantic City
Mally, Manuel, J., D.D.S., Atlantic City
Martucci, Paschal C., D.C., Atlantic City
McQuade John S., D.D.S., Atlantic City
Rechtman, A. M., Philadelphia, Pa.
Starkes, Col. Carlton C., Linwood
Steigerwald, Clarence S., D.C., Ventnor

HONORARY MEMBERS

Altman, Hon. Joseph, Atlantic City
Brown, Hon. W. Elmer, Atlantic City
Farley, Hon. Frank S., Atlantic City
Leonard, Hon. Leon, Atlantic City
Marcus, Joseph H., Los Angeles, Calif.
Mischlich, Richard, Esq., Egg Harbor

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Abarbanel, Milton G., 301 Rochelle av., Rochelle Pk.
Abbott, Charles C., 32 Main st., Lodi
Agayoff, John D., 127 S. Washington av., Bergenf'd
Alessi, Alfred A., 174 Merrison st., Teaneck
Alexander, Samuel, 108 Pascack rd., Park Ridge
Alexander, Stewart F., 108 Pascack rd., Park Ridge
Anderson, Ethelyn J. C., 195 Euclid av., Ridgefield P.
Anderson, Reuben M., 15 Anderson st., Hackensack
Andrick, Eugene A., 99 Sheridan av., Hohokus
Angiolettl, Louis V., 1617 Palisade av., Fort Lee
Appold, George D., 60 E. Church st., Bergenfield
Audl, Eugene H., 466 S. Maple av., Glen Rock
Baldwin, John F., 58 Ayers ct., West Englewood
Balze, Henry R., 218 Broad av., Leonia
Banta, Raymond E., 288 Orchard pl., Ridgewood
Barbash, Roslyn H. W., 835 Red rd., Teaneck
Barlow, Bernard G., Wright Aero. Corp.,Wood-Ridge
Barlow, G. Barton, 157 Engle st., Englewood
Barnes, William J., 155 Engle st., Englewood
Baron, Herbert A., 150 Terrace av., Hasbrouck Hts.
Basralian, Joseph B., 332 Wash'gt'n pl., Hasbr'k Hts.
Bayer, Eric C., 307 E. Madison av., Dumont
Beakes, Charles H. C., 155 Engle st., Englewood
Bednarz, Stephen, 219 Maple av., Wallington
Beres, Albert J., 189 A Valley Blvd., Wood-Ridge
Berke, Raynold N., 430 Union st., Hackensack
Berkow, Abraham, 417 Main st., Hackensack
Black, LeRoy W., 33 W. Passaic av., Rutherford
Blackman, Sadie, 12 Roosevelt av., Westwood
Bleasby, Charles B., 136 Passaic st., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bonanno, Peter J., 226 Engle st., Englewood
Bookstaver, Barnet S., 241 Cedar lane, Teaneck
Bosch, Taeke. 290 E. Franklin Turnpike, Hohokus
Braun, Joseph C., 531 Broad av., Palisades Park
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Ralph J., 301 Plaza rd., Fair Lawn
Brescia, James, 7 E. Franklin Turnpike, Waldwick
Brown, John L., 1019 Cumbermede rd., Palisade
Brozyna, Mieczyslaw, 194 Carlton av., E. Rutherf'd

Brunhofer, Andrew, 714 Cedar lane, Teaneck
Buckley, Paul J., 159 Palisade av., Bogota
Bump, Samuel C., 505 E. Ridgewood av., Ridgewood
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Burokus, William, 21 E. Pleasant av., Maywood
Busicco, Philip S., 131 Liberty rd., Englewood
Calabrese, Dino, 1022 Anderson av., Palisade
Caldwell, George W., 81 E. Clinton av., Tenafly
Campbell, Charles P., 397 Prospect av., Hackensack
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 366 Ridge rd., Lyndhurst
Carman, Henry E., 37 Selvage av., W. Englewood
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge
Caruso, Paul F., 194 Montross av., Rutherford
Casser, Leonard, 85 Margie av., Cresskill
Catania, Joseph P., 140 Passaic st., Garfield
Catanzaro, Vincent J., 316 Midland av., Garfield
Catapano, John, 21 Hazelton st., Ridgefield Park
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Clarie, D'Arcy C., 558 Broad av., Ridgefield
Clark, Margaret A., Glen rd., Woodcliff Lake
Cloud, Albert W., 139 Hugenot av., Englewood
Cole, Harold S., 19 Donaldson av., Rutherford
Cooper, Howard M., 37 Ridge rd., Rutherford
Corn, David, 541 Queen Anne rd., Teaneck
Costabile, Vincent, 324 Second av., Lyndhurst
Coughlin, Joseph J., 396 Union st., Hackensack
Crandall, John K., 200 Main st., Fort Lee
Cuddihy, Kathleen, 2023 Center av., Fort Lee
D'Agati, Vincent, 955 Queen Anne rd., Teaneck
D'Agostin, Henry, 243 Fulton ter., Cliffside Park
Dallio, Salvatore V., 463 Passaic av., Lodi
Daly, John F., 16 N. Brae ct., Tenafly
D'Amato, Charles R., 324 Hoboken rd., E. Rutherford
Dana, Edward, 163 Prospect av., Hackensack
Davis, Harold, 170 S. Washington av., Bergenfield
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford
DeCecio, Thomas, 691 Palisade av., Cliffside Park
Delafrange, Kenneth M., 96 Washington av.,Westw'd
DeLuca, Louis, 323 E. Ridgewood av., Ridgewood
DeSanto, Anthony M., 377 Essex st., Hackensack
Deuell, William D., 190 Elm av., Hackensack
Dezer, Charles N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Dolan, Gerald J., 247 Washington av., Hillsdale
Dresner, Evelyn E., 190 Park st., Ridgefield Park
Drews, Francis F., Jr., 530 Broad av., Englewood
Driggs, Marshall F., 242 Engle st., Englewood
Dul, Emil J., 154 Plauderville av., Garfield
Edgerly, Sherburn E., 220 Engle av., Englewood
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ellmers, Basil J., 304 Milford av., New Milford
Essertier, Edward P., 275 State st., Hackensack
Essertier, Harland C., 263 Franklin av., Ridgewood
Evans, J. Lawrence, Jr., 254 Christie Hgts.st., Leonia
Fadden, Francis J., Jr., 275 Engle st., Englewood
Farmer, Vincent, 430 Union st., Hackensack
Farr, Walter J., 955 Queen Anne rd., Teaneck
Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrante, Joseph, 803 Prospect av., Ridgefield
Ferrari, Andrew F., 196 Main st., E. Rutherford
Fessler, William, 31 Knox av., Cliffside
Fietti, Vincent G., 112 Ridge rd., Lyndhurst
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fioretti, Ralph J., 315 Rochelle av., Rochelle Park
Fitzhugh, William F., 190 Euclid av., Ridgefield Park
Fitzpatrick, Leo J., 541 Churchill rd., West Englew'd
Fliegel, William M., 85 W. Passaic st., Maywood
Follette, William J., 375 Engle st., Englewood
Forte, F. Chester, 374 Park st., Hackensack
Friedman, Abraham I., 405 State st., Hackensack
Friery, John F., 297 S. Washington av., Bergenfield
Gaspar, Istvan A., 407 Warwick av., W. Englewood
Gatti, Joseph D., 92 E. Hunter av., Maywood
Gershman, Joseph G., 185 E. Madison av., Dumont
Giordano, William C., 948 Maple av., Ridgefield
Gittelsohn, Isador, 700 Kinderkamack rd., River Ed.
Gitterman, David A., 519 Engle st., Englewood
Glick, Bernard, 307 Stuyvesant av., Lyndhurst
Goldberg, David, 336 Westwood av., Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Gorman, Robert B., 410 Kinderkamack rd., Oradell
Gould, Werner, 219 Passaic st., Hackensack
Grant, Russell B., 100 Prospect av., Hackensack
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, William J., 50 Anderson st., Hackensack
Grimes, Robert R., 134 Bergen av., Ridgefield Park
Groff, Parker A., 159 Washington av., Little Ferry
Grueninger, Edward F., 411 Cedar Lane, Teaneck
Guidice, Vincent W., Harrison av., Waldwick
Hagovsky, Albert J., 301 Hackensack st., Carlstadt
Halpern, Herman, 143 Engle st., Englewood
Harryman, William K., 271 Union st., Hackensack
Harwood, Harry L., 64 W. Central Blvd., Palisades P.
Hawes, Vernon L., 63 Church st., Ramsey
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, George, 460 Engle st., Englewood
Hensle, Otto S., 210 Main st., Hackensack
Hillsman, R. Bryan, 681 Queen Anne rd., Teaneck
Hirsch, John J., 191 Wallington av., Wallington
Hitzemann, Louis A., 35 Pangborn pl., Hackensack
Hoffman, George A., 234 Fort Lee rd., Leonia
Hoops, Harold J., 25 Woodland Park dr., Tenafly
Horowitz, Herman J., 872 Broad av., Ridgefield
Hull, Donald B., 88 W. Ridgewood av., Ridgewood
Hunziker, George P., 435 Warwick av., W. Englew'd
Irwin, John H., 242 Engle st., Englewood
Irwin, Robert C., 541 Page av., Lyndhurst
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jaslow, Seymour P., Godwin av., Wyckoff
Jenkins, Alvah R., 40 Armory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Jordan, Walter L., 145 Engle st., Englewood
Joseph, Solomon, 877 Queen Anne rd., Teaneck
Jukofsky, Isidore D., 335 Main st., Ridgefield Park
Kadisch, Ernst L., 120 Second av., Westwood
Kakascik, Emil J., 206 Palisade av., Garfield
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kelley, Charles B. P., 336 Engle st., Tenafly
Kemezis, Bitas, Closter Dock rd., Closter
Kennedy, Paul A., 147 Tenafly rd., Englewood
Kilts, Winfield S., 966 Garrison av., Teaneck
Kingslow, George L., 346 First st., Hackensack
Kissinger, Donald J., 315 Engle st., Tenafly
Klosterman, Julius A., 335 River rd., Bogota
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, William T., 210 Main st., Hackensack
Knowles, George M., 403 Prospect av., Hackensack
Knox, Charles A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 230 Kind'rk'in'k rd.,N.Hack's'k
Kristal, John, 292 Main st., Hackensack
Krudener, Robert D., 230 Fulton ter., Cliffside Park
LaBarba, Peter J., 163 Washington pl., Hasbr'k Hts.
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Langdon, Benjamin B., 450 Summit av., Hackensack
Latona, Joseph A., 78 Main st., Lodi
Law, Harrison E., 397 Prospect av., Hackensack
Legato, Samuel F., 432 Palisade av., Cliffside Park
Lemmerz, Willard H., 135 Hackens'k st.,Wood-Ridge
Lesko, Stephen W., 234 Mt. Pleasant av., Wallington
Levitas, George M., 199 Fairview av., Westwood
Levitas, Irving M., 199 Fairview av., Westwood
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., 1 Gilbert rd., Hohokus
Lichtenberg, Walter, 309 Kinderkamack rd.,Westw'd

Little, Rufus R., Bergen Pines Hospital, Oradell
Littwin, Charles, 950 Queen Anne rd., Teaneck
Liva, Arcangelo, P. O. Box 7, Hackensack
Liva, G. Albin, Madison av., Wyckoff
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
Loman, Samuel G., 139 Jefferson av., Cresskill
Lombardi, Frank L., 25 E. Clinton av., Bergenfield
Lord, C. Donald, 76 W. Ridgewood av., Ridgewood
Lowe, Louise, 248 State st., Hackensack
Luria, Sanford A., 249 Queen Anne rd., Bogota
Lynch, Maurice M., 46 Anderson st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englewood
Macaulay, Francis A., 819 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
MacLaren, Philip J., 3 Tenafly ct., Tenafly
Maddren, Russell F., 372 Union st., Hackensack
Mader, A. Ivan, Jr., 430 Union st., Hackensack
Magee, William P., 1009 Abbott blvd., Palisade
Mahoney, Thomas H., 321 Ridge rd., Rutherford
Mancene, Edward M., 225 Main st., Little Ferry
Mark, Harold I., 1022 Garrison av., Teaneck
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Frederick J., 539 Kinderkam'k rd.,River Edge
Mason, Stuart A., 756 E. Ridgewood av., Ridgewood
McAuliffe, Vincent, 910 Queen Anne rd., Teaneck
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McGee, Hugh E., 117 Cedar Lane, Teaneck
McIlveen, Marion, 260 Godwin av., Ridgewood
McLane, A. Donald, 498 Engle st., Englewood
McLeod, Harry J., 71 Forest rd., Tenafly
McWhorter, John E., 247 Mountain rd., Englewood
Mears, William G., 216 Hillside av., Leonia
Meehan, James S., Jr., 85 W. Main st., Bergenfield
Megibow, Harold J., 82 W. Main st., Ramsey
Merliss, Harry, 972 Main st., Hackensack
Mersch, Marcel A., 680 Broad av., Ridgefield
Metz, Henry, 445 Prospect av., Hackensack
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Minck, Peter, Jr., East Saddle River rd., Saddle R.
Mockett, Walter W., 55 E. Magnolia av., Maywood
Modrys, Walter F., 714 Palisade av., Cliffside Park
Mores, Herbert R., 321 Union st., Hackensack
Moss, Jack W., Maple av., Wyckoff
Muller, Frederick L., 511 Broad st., Carlstadt
Mulligan, Luke A., 230 Fort Lee rd., Leonia
Myers, Norman V., 136 Engle st., Tenafly
Naclerio, Amedeo, 207 Hackensack st., Wood-Ridge
Nemiroff, Nathan, 348 Kinderkamack rd., Oradell
Netz, Lester W., 210 Main st., Hackensack
Neville, Robert J., 547 Main st., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
Olpp, John L., 49 Ivy lane, Tenafly
Oren, Hyman, 74 Perry st., Park Ridge
Padden, Aloysius F., 335 Orchard ter., Bogota
Pagano, Peter, 324 Franklin av., Ridgewood
Palazzo, William L., Holy Name Hosp., Teaneck
Pallen, Conde deS., 6 Passaic st., Rochelle Park
Patti, Frank A., 241 Broad av., Leonia
Pedevill, Joseph R., 232 Highland av., Palisades Park
Pellegrini, Vincent J., 8 Summit av., Hackensack
Persico, Anthony, Columbus av., Harrington Park
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
Pindar, Irene D., 164 Selvage av., West Englewood
Pindar, William A., Jr., 59 Bradley av., Bergenfield
Policastro, Nelson C., 378 Union st., Hackensack
Pollack, Roy, 715 Palisade av., Cliffside Park
Prall, Henry E., 755 Anderson av., Cliffside Park
Prather, Charles G., 25 Westwood av., Westwood
Prather, John W., 155 Washington av., Dumont
Protzman, Thomas B., 314 Engle st., Englewood
Rader-Hoheb, Katherine A., 5 Lincoln av.,Rutherf'd
Rappaport, Doris I., 1363 Sussex rd., W. Englewood
Ravits, Everett C., 5 Pangborn pl., Hackensack
Re, Natale M., 1003 Dearborn rd., Palisade
Reich, Samuel B., 286 Union st., Hackensack
Reid, Erwin W., 125 Marsellus pl., Garfield
Reinhold, H. E., 441 W. Englewood av., W.Englewood
Reitnauer, John S., 6 Standish ct., Tenafly
Rentrop, Charles A., Jr.,364 E.Ridgew'd av.,Ridgew'd
Rhodes, Harry, Jr., 171 Terrace av., Hasbrouck Hts.
Richards, Ernest W., 374 DeWolf pl., Hackensack
Richardson, Charles A., Closter Dock rd., Closter
Roberts, Charles D., 188 Sherwood pl., Englewood
Romano, Anthony M., 159 Westervelt av., Tenafly
Rooks, Wendell H., Wyckoff
Rosenbauer, Howard J., 120 Clinton pl., Hackensack
Rosner, Francis, 653 Maywood av., Maywood
Ross, Bernard, 30 E. Passaic st., Maywood
Roth, Daniel B., 836 Garrison av., Teaneck
Rothschild, Carl E., 275 Grand av., Englewood
Rowohlt, George O., 150 E. Madison av., Dumont
Roylance, F. Dean, Jr., St. Nicholas av., Haworth
Rube, Joseph A., 145 Prospect st., Ridgewood
Rusin, Michael, 81 Monroe st., Garfield
Ryley, Harold W., 1 Lincoln pl., E. Rutherford
Salva, Edo J., 17 W. Central blvd., Palisades Park
Sandler, Moses, 2013 Center av., Fort Lee
Sandler, Samuel A., 254 Union st., Hackensack
Sarajian, Aram M., 88 W. Forest av., W. Englewood
Sarla, Michael, 55 Hudson st., Hackensack
Scerbo, Ernest, 33-14 Broadway, Warren Point
Schaberg, Frank J., 263 Anderson st., Hackensack
Scheer, Eli, 885 Queen Anne rd., Teaneck
Schiro, S. Robert, 73 Main st., Lodi
Schmidt, Walter W., 386 Palisade av., Cliffside Park
Schretzmann, Rudolph C.,1289 Trafalger st.,W.Eng'w'd
Schultz, Leo P., 232 Franklin Tnp., Allendale
Schwartz, Leon J., 88 Park av., Rutherford
Scullion, Arthur A., 460 Anderson av., Cliffside Park
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seidel, Reginald F., 164 Maple st., Englewood
Seiler, Benjamin, 580 Palisade av., Cliffside Park
Sexton, Edward V., 936 Queen Anne rd., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Sharlin, Herbert S., 301 Union st., Hackensack
Siegel, Simeon, 167 Washington av., Dumont
Sklar, S. Harvey, 647 Anderson av., Cliffside Park
Skvarla, John A., 17 Koster st., Wallington
Sloane, Milton B., 128 W. Hudson av., Englewood
Smith, Bryan A., 10 N. Monroe st., Ridgewood
Smith, Nehemiah E., 29 Bennett rd., Englewood
Snedecor, Spencer T., 210 Main st., Hackensack
Solworth, Lee, 309 Engle st., Englewood
Somers, Willard H., 157 Engle st., Englewood
Sosnow, Louis M., 51 Central av., Hillsdale
Sperber, Thomas J., 714 Cedar lane, Teaneck
Spiegelglass, Abraham B., 417 Main st., Hackensack
Spranz, William S., 546 Oradell av., Oradell
Stassi, Anthony, 481 Passaic av., Lodi
Stein, Frederick, 620 Ridge rd., Lyndhurst
Sullivan, John A., 764 Queen Anne rd., Teaneck
Susinno, Anthony M., 29 Roff av., Palisades Park
Szot, Alexander, 747 Ridge rd., Lyndhurst
Tennis, Edgar M., 375 Engle st., Englewood
terKulle, Reinold W., 88 W. Ridgewood av.,Ridgew'd
Tether, Russell K., Main st., Closter
Tomlins, Francis I., 97 Madison pl., Ridgewood
Toscano, George A., 364 Park st., Hackensack
Vanderbeek, Stuart W., 143 Engle st., Englewood
Vandersluis, Harold H., 40 Pascack rd., Park Ridge
Vann, Dorothea D., 460 Engle st., Englewood
Vann, Felix H., 179 Hillside av., Englewood
Van Riper, William D., 441W.Eng'w'dav.,W.Eng'w'd
Van Winkle, Charles I., 79 Ridge rd., Rutherford
Vargish, Hildegard S., 268 Kinderk'm'k rd.,N.H'k's'k
Vargish, Jacob, 268 Kinderkamack rd., N. Hackens'k
Verdon, Robert E., 682 Anderson av., Cliffside

Vita, Frank J., Army
Vroom, William L., 88 W. Ridgewood av., Ridgewood
Walker, Nelson C., 261 Summit av., Hackensack
Ward, Mary, 30 Engle st., Tenafly
Warren, Charles B., 181 Prospect av., Bergenfield
Weiss, Samuel A., 786 Palisade av., Teaneck
White, Frank S., 916 Red rd., Teaneck
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Widetsky, Alfred, 85 Broadway, East Paterson
Williams, Edith B., 70 Anderson st., Hackensack
Williams John R., 681 Anderson av., Cliffside Park
Williams, William C., 9 Ridge rd., Rutherford
Willis, Benedict P., 185 Montross av., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 790 Grange rd., Teaneck
Witkoff, Benjamin, 215 Terrace av., Hasbrouck Hts.
Wolfe, Edward E., 895 Queen Anne rd., Teaneck
Wollack, Alfred, 9 Park av., Park Ridge
Wolowitz, Harry B., 20 Spring Valley av., Hack'ns'k
Worcester, George F., 220 Engle st., Englewood
Worcester, John T., 220 Engle st., Englewood
Wren, James C., 79 Everett st., Closter
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., 331 River rd., New Milford
Zacchino, Arnold A., 1001 Anderson av., Palisade

ASSOCIATE MEMBERS

Balakian, Gerard, 131 Ayers ct., West Englewood
Bibbo, Canio, 130 Kensington rd., River Edge
Bitsack, Joseph W., 210 Main st., Hackensack
Brodek, Hans D., 218 Broad av., Leonia
Diamond, Paul, 372 Fairview av., Westwood
Eccleston, Herbert H., 124 Elm av., Hackensack
Eisenstein. Bernard, 276 Engle st., Englewood
Friedland, Walter, 210 Main st., Hackensack
Gresser, Newton H., 286 Union st., Hackensack
Helden, Gerard O., 15 Anderson st., Hackensack
Higdon, Albert L., 411 Cedar Lane, Teaneck
Iandoli, John, 227 Washington av., Westwood
Jenkins, John R., Jr., 15 Pleasant ct., Maywood
Katz Michael M., 197 S. Washington av., Bergenfi'd
Kley, Edward, 199 Dorchester rd., River Edge
Kloth, Edward W., 254 Christie Heights st., Leonia
Krull, Barnard, 811 Queen Anne rd., Teaneck
Midura, Peter, 116 Prospect st., Ramsey
O'Connor, John P., 984 Queen Anne rd., Teaneck
Ridley, James B., 162 Engle st., Englewood
Scales, Harold L., 805 Red rd., Teaneck
Sciano, Edward A., 109 Broadway, E. Paterson
Webb, Wilson D., Jr., 248 State st., Hackensack
Williams, William E., 9 Ridge rd., Rutherford

COURTESY MEMBERS

Beaugard, Peter A., Fair Lawn
Brown, Leonard, New York, N. Y.
Carey, Benjamin W., Westwood
Coca-Fernandez, Arthur, Oradell
Denison, Ward C., Paterson
Fitzgerald, Joseph M., New York, N. Y.
Franklin, Sidney, Youngstown, Ohio
Hardy, Stanton M., Montvale
Kassel, Mortimer H., East Paterson
Katzin, Herbert M., Teaneck
Lewin, Michael L., Paterson
Mayer, David M., Rutherford
Opitz, Russell B., Palisade
Otvos, Emery G., Palisade
Twinem, Francis P., Hackensack
Vance, Maude V., Palisade
Wright, Howard A., Ridgefield

HONORARY MEMBERS

Burbank, Hugh E., Lyndhurst
Robinson, Silas E., Waldwick
Tidwell, George W., Rutherford

EMERITUS MEMBERS

Van Dyke, Joseph S., Palisades Park
Whittaker, Neil M., Teaneck

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Regular meetings on second Thursday evening of each month except June, July and August, at Riverton Country Club, Riverton. Annual Meeting in May.

ACTIVE MEMBERS

Bauer, John T., 312 E. Second st., Moorestown
Betsch, William F., 220 Pleasant Val. av.,Moorest'n
Betts, R. Winfield, 22 N. Main st., Medford
Boudwin, Norman K., 64 Church st., Beverly
Bray, William E., 41 Elizabeth st., Pemberton
Buckley, Richard T., Jr., 111 E. Main st.,Maple Shade
Busansky, Samuel T., Trenton rd., Browns Mills
Cicione, Edward, 621 Highland av., Palmyra
Davis, E. Vernon, 306 E. Main st., Moorestown
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Elwell, Alfred M., Jr., 149 E. Main st., Moorestown
Elwell, Robert W., 215 Center av., Delanco
Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly
Haldeman, Robert E., 34 Garden st., Mt. Holly
Hartman, Luther M., 111 E. Main st., Maple Shade
Hebble, Howard M., 320 Chester av., Moorestown
Hornberger, J. Howard, 4th & Main sts., Roebling
Kuder, Joseph M., 104 Garden st., Mt. Holly
Landis, Harry P., Jr., 901 Columbia av., Palmyra
LeFavor, Dean H., 619 Morgan av., Palmyra
Leonard, Bernard 33 W. Union st., Burlington
Longsdorf, Harold E., Bartram av., Mt. Holly
Love, Elizabeth F., Jeanes Hospital, Phila, Pa.
Lucas, W. Fred, 23 W. Broad st., Burlington
MacNeal, Perry S., 417 Chester av., Moorestown

Mark, Harry B., 600 Elm ter., Riverton
Mazur, Edward F., 540 Bridgeboro rd., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Mills, Charles S., 106 Lippincott av., Riverton
Mulford, William P., 202 Warren st., Beverly
Newcomb, Marcus W., Browns Mills
Peacock, Arthur B., 201 E. Main st., Moorestown
Provenzani, Dominico, 419 Locust av., Burlington
Rodman, E. Warren, 503 Cooper st., Beverly
Sand, Abraham B., 207 E. Union st., Burlington
Schaeffer, Alan M., 229 Willow st., Delanco
Schisler, Milton M., Second & Church sts., Florence
Sparks, Paul R., 102 W. Broad st., Burlington
Stokes, S. Emlen, 129 Chester av., Moorestown
Summey, Thomas J., 800 Golf View rd., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. Bartine, 199 Chestnut st., Moorestown
Van Meter, Ralph H., 224 E. Main st., Moorestown
Viteri, Luis E., 214 Main st., Mt. Holly
Voorhis, Charles F., 330 Morgan av., Palmyra
Wade, George R., 129 Chester av., Moorestown
Wescoat, George N. A., 202 W. Main st., Moorestown
Whitaker, John C., 402 Lippincott av., Riverton
Wildman, Edward D., 119 Chester av., Moorestown
Wyman, Edward H., 100 E. Broad st., Burlington

EMERITUS MEMBERS

Conroy, John S., Burlington
Darlington, Emlen P., New Lisbon
Hunter, Edward R., Delanco
Mendenhall, Clinton D., Bordentown
Metzer, Emma P. W., Riverside

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

ACTIVE MEMBERS

Amato, Charles P., 500 Cooper st., Camden
Anderson, Merton B., 727 Walnut st., Camden
Andrus, David L., 805 Cooper st., Camden
Asbell, Nathan, 326 Cooper st., Camden
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 618 Benson st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 524 Cooper st., Camden
Barroway, James N., 2714 Westfield av., Camden
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bekampis, Eugene H., 315 E. Maple av., Merchantv'e
Bentley, David F., Jr., 406 Cooper st., Camden
Bernell, Stanley P., 1207 Haddon av., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Bianco, John J., 318 Cooper st., Camden
Bibighaus, Warren Y., 313 4th av., Haddon Heights
Bowen, Robert N., 419 Cooper st., Camden
Boysen, Otto T., 2704 Westfield av., Camden
Braun, William, 406 Cooper st., Camden
Breme, Julius C., 523 Walnut av., Laurel Springs
Brennan, Charles L. S., 14 S. Broadway, Gloucester
Brennan, John P., 14 Church rd., Merchantville
Brown, Marcus, 2 White Horse Pike, Haddon Hts.
Brown, Stanley L., 517 Cooper st., Camden
Browning, Wm. J., 134 N. Center st., Merchantville
Burns, Wilmer F., 267 White Horse Pike, Audubon
Bush, Ralph K., 23 E. Maple av., Merchantville
Butler, Samuel S., 1100 Kaighn av., Camden
Carlander, Oswald R., 130 N. Broadway, Camden
Carmona, Manuel G., 141 Wood st., Tuckerton
Casselman, Arthur J., 301 N. Second st., Camden
Ciliberti, Frank J., Jr., Fifth & Pine sts., Camden
Clark, Ernest W., 414 Cooper st., Camden
Clark, Morris B., W. Pine and Atl. avs., Audubon
Cohen, Leon, 2424 Baird Blvd., Camden
Cohen, Paul, 500 State st., Camden
Collier, Martin H., 406 Cooper st., Camden
Conlen, Richard, 523 Haddon av., Camden
Connell, James, 337 Monmouth st., Gloucester
Cooper, Robert A., 7137 E. Park av.,PennsaukenTwp.
Coriell, Lewis L., Municipal Hosp., Camden
Costanzo, Joseph J., White Horse av., Clementon
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 211 N. Fifth st., Camden
Crowley, Joseph W., 4005 Westfield av., Camden
Cunningham, Joel B., 801 Cooper st., Camden
David, Leopold S., 326 Cooper st., Camden
Davis, Albert B., 511 Cooper st., Camden
Davis, J. Stannard, 55 Kings Highway, E.,Haddonf'd
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
Del Duca, Vincent P., 514 Cooper st., Camden
Denbo, Elic A., 596 Benson st., Camden
Dickensheets, Jas. G., 4405 Westfield av., Penns'k'n
Di Ielsi, Anthony J., 1013 S. Fifth st., Camden
D'Imperio Francesco, 411 Cooper st., Camden
Dorkin, Jerome R., 2908 Federal st., Camden
Drake, Willard M., Jr., 406 Cooper st., Camden
Driscoll, Charles D., 475 White Horse P.,W.Col'gsw'd
Drossner, Jacob L., 1300 Park Blvd., Camden
Durham, Frederick W., 20 Kings Hwy., W., H'dd'nf'd
Ebner, Paul G., 408 Overhill rd., Haddonfield
Ellis, Alexander, 519 Broadway, Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., 538 Cooper st., Camden
Eynon, James R., 20 E. Knight av., Collingswood
Farrell, Edgar A. H., 26 Kings Highway,W.,H'd'nf'ld
Fessman, John W., 114 Clements Brg.rd.,Runnemede
Fidler William L., III, Brace rd., Haddonfield
Filkins, Cedric E., 412 White Horse Pike, Audubon
Filsinger, Carl W., 109 W. Maple av., Mechantville
Frantz, Max K., 624 S. Fifth st., Camden
Fridrich, Harry E., 4172 Federal st., Camden
Friedenberg, Sidney, 2990 Alabama rd., Camden
Gamon, Robert S., 514 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, George B., 15 W. Walnut av.,Merchantville
Gilbert, Philip D., 514 Cooper st., Camden
Girardo, Anthony J., 22 Taunton av., Berlin
Gleason, Edwin A., 115 Wesley av., Erlton
Glover, Lawrence L., 53 Kings Highway W., H'd'f'ld
Goldman, Samuel, 414 Cooper st., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Gosper, Ralph W., 5719 W'stf'd av., Penns'kenTwp.
Grenhart, George W., 714 Market st., Camden
Griffey, William C., 1049 Haddon av., Collingswood
Griscom, Lee E., 604 Broadway, Camden

Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Hager, George W., Jr., Eighth & Market sts.,C'md'n
Haines, Keith E., 300 S. Broadway, Camden
Haines, Mabel C. S., 600 White Horse Pike, Audubon
Halbeisen, William A., 511 Cooper st., Camden
Hallinger, Earl S., 517 Cooper st., Camden
Hammett, Lee J., 760 N. 27th st., Camden
Hanson, Alfred S., 33 Cuthbert blvd., Westmont
Harbeson, James P., III, 460 Loucraft rd., Haddonf'd
Hays, Roy G., 527 Haddon av., Collingswood
Hemphill, Everett H., 274 Kings H'way, E., Had'nf'd
Hessert, Edmund C., 417 Cooper st., Camden
Hirshorn, Arthur, 539 Monmouth st., Gloucester
Hofer, William R., 125 Main st., Williamstown
Hollinshed, Beulah S., 600 Benson st., Camden
Horner, John I., 137 W. Kings Highway, Audubon
Howard, J. Edgar, 67 Kings H'way, W., Haddonf'd
Hughes, A. Joseph, Third & Cooper sts., Camden
Hughes, Frank J., 429 Cooper st., Camden
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hussong, Wallace B., 225 N. Seventh st., Camden
Husted, Gerald W., 306 Eighth av., Haddon Heights
Imhoff, Robert E., 527 Penn st., Camden
Ironside, Paul A., 144 North dr., Haddonfield
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Charles H., 1250 Park Blvd., Camden
Johnson, Herbert F., 429 Cooper st., Camden
Jones, John C., 805 Princeton av., Camden
Judson, G. Vernon, Jr., 722 Redman av., Haddonfield
Kain, Thomas M., 403 Cooper st., Camden
Kain, Thomas M., Jr., 403 Cooper st., Camden
Kay, Albert E., 5 W. Chestnut av., Merchantville
Keller, Earl B., Jr., 604 White Horse Pike, Oaklyn
Kelly, Frank, 11 N. Johnson Blvd., Gloucester
Kennedy, George R., 517 Cooper st., Camden
Kerdasha, Richard F., 937 Monmouth st., Gloucester
Keyser, David, 1518 Baird av., Camden
Kimler, William D., 400 Collings av., Collingswood
Kinney, Albert G., 609 Clinton av., Haddonfield
Klarich, Philip, 512 Broadway, Camden
Kline, Oram R., 514 Cooper st., Camden
Klinger, John S., 1452 Mt. Ephraim av., Camden
Kutner, Charles, 211 N. Fifth st., Camden
Larossa, Ernest A., 561 Benson st., Camden
Lee, Benjamin F., Broadway Stevens Bldg., Camden
Lee, Thomas B., 622 Cooper st., Camden
Locke, Henrik W., 243 W. Main st., Moorestown
MacAlpine, Kenneth B., 500 Chews Ldg. rd.,Had'nf'd
Magee, Edward S., 201 White Horse Pike, Audubon
Magee, Russell S., 201 White Horse Pike, Audubon
Maldeis, A. M. K., 117 N. Sixth st., Camden
Marcarian, Henry G., 917 Cooper st., Camden
McAfoos, Louis G., Jr., 346 Richey av., Collingswood
McCallum, Arthur S., 213 Clements Br. rd., Bar'gt'n
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thomas P., 10th & Cooper sts., Camden
McDermott, Vincent T., 509 State st., Camden
McGlade, Thomas H., 1225 Walnut ave., W.Col'gsw'd
McWilliams, Charles E., Church st., Blackwood
Mecray, Paul, Jr., 405 Cooper st., Camden
Mecray, Paul M., 405 Cooper st., Camden
Meyer, Eugene A., 427 Cooper st., Camden
Meyer, George P., 410 Haddon av., Camden
Milnamow, Paul, 318 Cooper st., Camden
Murray, Edwin N., 130 N. Broadway, Camden
Musulin, Nicholas R., 514 Cooper st., Camden
Newmeyer, Joseph, 47 S. 27th st., Camden
Noone, Thomas A., 416 Broadway, Camden
Olivo, Matthew, 419 Cooper st., Camden
Ornaf, I. Edward, 1145 Thurman st., Camden
Osborn, Edward G., 3194 Alabama rd., Camden
Paisley, Ellwood S., 501 White Horse Pk., Haddon H.
Palmisano, Vincent S., 13 W. 6th av., Runnemede
Pike, Charles E., 4 E. Haddon av., Oaklyn
Pinsky, Harry A., 209 S. Sixth st., Camden
Pinto, Joseph, Navy
Pisciotta, Vincent, 23 Oak st., S., Mt. Ephraim
Platt, William, West Jersey Hospital, Camden
Pratt, Arthur G., 516 Cooper st., Camden
Preis, Edwin E., 3300 Federal st., Camden
Price, Henry S., Jr., 150 Frazer av., Collingswood
Principato, Roberto, 402 Walnut st., Camden
Raban, Reginald J., 1185 Yorkship Square, Camden
Rapp, Robert F., 994 Haddon av., Collingswood
Read, William T., Jr., Cooper Hospital, Camden
Reilly, Joseph, 600 Newton av., Oaklyn
Repici, Anthony J., 212 Haddon av., Haddonfield
Rhone, David S., 1202 Haddon av., Camden
Riegert, Louis C., 808 Kings H'way, Haddon Hts.
Ristine, Edwin R., 300 Broadway, Camden
Roberts, Joseph E., Jr., 403 Cooper st., Camden
Roberts, Richard H., 53 Kings H'w'y, W., Haddonf'd
Rose, Francis L., 511 Cooper st., Camden
Rosenberg, Hyman, 318 Cooper st., Camden
Rosner, Edwin, 814 Haddon av., Collingswood
Rudolph, John P., 108 W. Maple av., Merchantville
Russell, Marie E., 583 Haddon av., Collingswood
Ruttenberg, Louis, 19 Hopkins st., Woodbury
Ruttenberg, Max, 303 Cooper st., Camden
Ryan, Lawrence W. F., 922 Haddon av., Collingsw'd
Santor, Daniel, 27 E. Taunton av., Berlin
Schall, Reuben E., Seventh & Elm sts., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
Schellenger, Edward A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. Fifth st., Camden
Schwartz, Henry C., Raritan av., Atco
Seely, Richard H., 514 Cooper st., Camden
Selberling, Joseph D., 225 Redman av., Haddonfield
Seto, Stanford P. T., P. O. Box 138, Blackwood
Shaen, Edward, 701 N. Sixth st., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, F. William, 634 Penn st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 311 Collings av., W. Collingswood
Shaw, Ned, 514 Cooper st., Camden
Sheaffer, Clinton P., 241 Kings H'way, E., Had'nf'd
Shemeley, William G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, James S., 514 Cooper st., Camden
Shipps, Hammell P., 719 Cooper st., Camden
Shope, Edward P., 150 N. Broadway, Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Silberstein, Frederick H., 4711 Westfield av.,M'rc'tv'e
Siniscalco, Salvatore, 801 S. Fourth st., Camden
Skyer, Joseph, 3400 Federal st., Camden
Skyer, Roslyn P., 3400 Federal st., Camden
Smith, Bertram H., 1000 Kings Highw'y,Hadd'nHts.
Snagg, William T., 719 Cooper st., Camden
Snape, William J., 573 Stevens st., Camden
Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
Spevack, Max, 536 Market st., Gloucester
Stein, Joseph M., 414 Cooper st., Camden
Stephenson, Daniel H., 8th and Market sts., Camden
Stetser, Leland M., 414 Cooper st., Camden
Stone, Frank P., 234 Fairmount av., Laurel Springs
Storer, Alexander, Jr., 563 Haddon av., Collingswood
Straus, Frederick W., 2708 Westfield av., Camden
Sturr, Robert P., Jr., 129 Fourth av., Haddon Hts.
Sufrin, Emanuel, 1529 Wildwood av., Camden
Sullivan, Claude C., Jr., 201 S. Logan av., Audubon
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, Martin E., 9 Second av., Haddon Heights
Tatem, Henry R., Jr., Pino st., Audubon
Thompson, P. H., 4612 W'stf'd av., Pennsauken Twp.
Traganza, Robert W., 428 Richey av., W.Collingsw'd
Tyler, Charles O., 134 Kings H'w'y, E., Haddonfield
von Deilen, Arthur W., 530 Cooper st., Camden

Warwick, Ralph A., 3300 Federal st., Camden
Waugh, Bascom S., 1882 S. Tenth st., Camden
Weimann, Max L., 803 Station av., Haddon Heights
Wiant, Herman E., 120 Windsor av., Haddonfield
Wiggins, Ulysses S., 1025 S. Fourth st., Camden
Williams, William C., Black Horse Pk., Haddon Hts.
Wilson, Lester R., 3320 Federal st., Camden
Winter, Carl M., 1518 Collings rd., Camden
Wright, Ralph S., 517 Cooper st., Camden
Wroblewski, Benj. M., 1166 Thurman st., Camden
Yasskin, Hymen E., 575 Stevens av., Camden

HONORARY MEMBERS

Clement, Lavinia B., Haddonfield
Eaton, Arthur T., Haddon Heights
Lovett, Joseph C., Ardsley, Pa.
Mecray, Paul M., Camden
Pratt, William H., Camden
Richardson, Emma M., Camden
Roberts, Joseph E., Jr., Camden
Rossell, Edward W., Colwick
Shafer, F. William, Camden
Van Sciver, John E. L., Haddonfield

EMERITUS MEMBERS

Eaton, Arthur T., Haddon Heights
Lovett, Joseph C., Ardsley, Pa.
Richardson, Emma M., Camden
Rossell, Edward W., Colwick
Van Sciver, John E. L., Haddonfield

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on fourth Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

ACTIVE MEMBERS

Barrows, Victor I., 106 W. 11th st., N. Wildwood
Bernheisel, Louis E., Marshallville rd., Tuckahoe
Brooks, George M., 18 N. Main st., Cape May Ct. H.
Cameron, C. Paul, 720 Shore rd., Somers Point
Cohen, Maurice B., 224 E. Wildwood av., Wildwood
Cornwell, Robert A., 717 Wesley av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., 109 Mechanic av., Cape M. Ct. H.
Dandois, George F., 220 E. Wildwood av., Wildwood
Eisenhower, J. S. D., 2704 Pacific av., Wildwood
Fath, Marcus A., 108 E. Glenwood av., Wildwood
Furey, Joseph A., 224 E. Wildwood av., Wildwood
Hauck, Francis A., 4614 Landis av., Sea Isle City
Hirsch, Arthur, 811 DeHirsch av., Woodbine
Hornstine, Harry H., 4004 Pacific av., Wildwood
Hughes, Harold F., Ocean st. & Columbia av.,CapeM.
Hughes, Samuel B., 246 E. Pine av., Wildwood
Markowitz, Isidor, Army
Mazzotta, Samuel, 5806 Pacific av., Wildwood
Moir, John A., 18 N. Main st., Cape May C'rt House
Monosson-Friedland, Ida, 200 N. East av., Vineland
Pettit, Herschel, 807 Wesley av., Ocean City
Records, Carl J., Franklin & Sewell avs., Cape May
Schwarz, Leopold, 237 E. Pine av., Wildwood
Smith, Marcia V., 821 Wesley av., Ocean City
Steel, William A., Beesley's Point
Townsend, John B., 824 Wesley av., Ocean City
Tyson, Edward B., 391 55th st., Ocean City
Wallen, Benjamin B., 217 E. Pine av., Wildwood
Way, Clarence W., 4515 Landis av., Sea Isle City
Whiticar, John H., Box 235, Ocean City
Yingling, Paul L., 804 Wesley av., Ocean City

HONORARY MEMBERS

Quigley, Frederic J., Jersey City
Ulmer, Chester I., Gibbstown

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

ACTIVE MEMBERS

Aitken, Frank J., 62 N. Pearl st., Bridgeton
Anastor, Herbert C., 641 Wood st., Vineland
Ayars, Paul K., Main & Temperance sts.,Port Norris
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Hugh W., Eighth & Elmer sts., Vineland
Bardfeld, Benjamin B., 1080 E. Landis av., Vineland
Bellak, Ellis R., Leesburg
Berkowitz, Benjamin, 188 E. Commerce st.,Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Brown, Robert C., 318 N. Second st., Millville
Butcher, Charles, Heislerville
Carll, Jesse W., 129 Broad st., Bridgeton
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, Jr., 716 Wood st., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
DeSantis, Orazio J., 131 N. Third st., Millville
Friedland, Arnold J., 200 N. East av., Vineland
Fromkin, Charles, 20 Bank st., Bridgeton
Garrison, Sherman, 108 W. Commerce st., Bridgeton
Giacalone, Vincent, 58 North Valley av., Vineland
Gray, Charles M., 6th & Grape sts., Vineland
Greene, Edwin C., 61 N. Pearl st., Bridgeton

Gricco, Anthony L., 306 S. East av., Vineland
Hansen, Kurt M., 410 N. Third st., Millville
Harris, Maurice N., 205 Irving av., Bridgeton
Hendrickson, Harold W., Edgewood av., Cedarville
Henry, Norman, 643 Wood st., Vineland
Kauffmann, Louis J., 228 N. Second st., Millville
Knowles, James S., 318 N. Second st., Millville
Kratka, William H.. 188 N. Pearl st., Bridgeton
Kump, Albert B., 39 Lake st., Bridgeton
Lang, Paul, 32 W. Commerce st., Bridgeton
Loder, Horace B., 225 E. Commerce st., Bridgeton
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Madi, Risley J., 735 Montrose st., Vineland
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 105 S. East av., Vineland
Mascara, Gaetano A., 540 Wood st., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Palladino, Alessandro, 86 W. C'mm'rce st., Bridgeton
Phillips, Ralph S., 27 S. Giles st., Bridgeton
Pino, Anthony, 196 Irving av., Bridgeton
Pole, Samuel B., 200 W. Commerce st., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Reinhart, Harry A., 80 South Myrtle st., Vineland
Rosen, Sol, 214 N. Second st., Millville
Rosiello, Louis E., 712 Wood st., Vineland
Ruggieri, Pasquale, 803 Elmer st., Vineland
Scott, Leonard G., 496 E. Commerce st., Bridgeton
Sewall, Arthur D., 52 N. Pearl st., Bridgeton
Shapiro, Albert B., 103 N. East av., Vineland
Sharp, Charles E., Main st., Port Norris
Sheppard, Alfred G., 309 Broad st., Elmer
Sheppard, Muse A., Broad & Penn sts., Elmer
Sheppard, Thomas S., 21 E. Vine st., Millville
Siegel, Sidney L., 227 N. Second st., Millville
Sussman, Irvin, 241 E. Commerce st., Bridgeton
Sydoriak, Vladimir L., 51 Park Blvd.,Lancaster,N.Y.
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 8th & Grape sts., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland

HONORARY MEMBERS

Elmer, Matthew K.
Lore, Harry E., Cedarville
Neal, Charles B., Millville
Simkins, Raymond, Bridgeton

EMERITUS MEMBERS

Elmer, Matthew K.
Neal, Charles B., Millville
Simkins, Raymond, Bridgeton

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

ACTIVE MEMBERS

Abel, Arthur R., Orange Memorial Hosp., Orange
Abrams, Abram B., 299 Clinton av., Newark
Adelman, Benjamin B., 186 Clinton av., Newark
Agnew, Hobart M., 17 Plymouth st., Montclair
Albano, Edwin H., 144 Harrison st., East Orange
Albano, Frank J., 535 N. Seventh st., Newark
Albano, Joseph, 535 N. Seventh st., Newark
Alcamo, John H., 321 S. Ninth st., Newark
Alexander, John W., 308 Main st., Orange
Alexander, Walter G., 48 Webster pl., Orange
Allan, James S., 144 Harrison st., East Orange
Allen, Chester B., Jr., 42 Gordonhurst av., Montclair
Allen, Raymond N., 144 Harrison st., East Orange
Alterbaum, George, 25 Park av., Caldwell
Altman, Charles D., 116 Fairmount av., Newark
Amato, John R., 1134 Broad st., Newark
Ambrose, Anthony, 15 Washington st., Newark
Amster, Milton W., 439 Meeker st., South Orange
Anderson, Robert C., 686 Mt. Prospect av., Newark
Anderson, William A., 1310 Broad st., Bloomfield
Angelillo, Marc C., 177 Elwood av., Newark
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, William A., 24 Stengel av., Newark
Anuario, Charles B., 365 S. Centre st., Orange
Applebaum, Irving L., 31 Lincoln Park, Newark
Arons, Harry, 31 Lincoln Park, Newark
Ash, Samuel, 866 So. 13th st., Newark
Aszody, Paul, 340 Waverly av., Newark
Auerbach, Friedrich, 490 Stuyvesant av., Irvington
August, Jacob, 149 Rhode Island av., East Orange
Autorino, Ralph R., 10 Harrison av., Montclair
Bachmann, William, 87 Hillcrest ter., East Orange
Bacote, Ernest F., 680 High st., Newark
Baime, Jules E., 72 Prospect st., East Orange
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Baker, Maclyn F., 987 Sanford av., Irvington
Balis, Samuel B., 67 Baldwin av., Newark
Balsamo, Joseph J., 224 So. Eighth st., Newark
Balson, Zachary D. B., 49 Osborne ter., Newark
Barbella, Joseph D., 498 N. 13th st., Newark
Barkhorn, Charles W., 223 Roseville av., Newark
Barnard, Frank G., 79 Hawthorne pl., Montclair
Barrett, James, 252 N. Arlington av., East Orange
Barrett, John E., 220 Woodside av., Newark
Barrett, Joseph F., 230 Parker av., Maplewood
Bass, Morris, 414 Chancellor av., Newark
Bass, Rose D., 54 Lyons av., Newark
Baum, Felix, 406 Centre st., South Orange
Baum, Lewis F., 406 Centre st., South Orange
Baum, Otto S., 406 Centre st., South Orange
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 862 S. 13th st., Newark
Bauman, Rush C., 92 High st., Nutley
Becker, Martin, 66 Hawthorne av., East Orange
Becker, Marvin C., 299 Clinton av., Newark
Becker, Sylvia F., 299 Clinton av., Newark
Beirne, Donald P., 435 N. Arlington av., East Orange
Belling, C. Abbott, 15 Washington st., Newark

Bell, Horace O., Essex Co. Isolation Hosp., Belleville
Bellucci, Frank D., 300 Mt. Prospect av., Newark
Belott, August V., 129 Main st., West Orange
Belott, Louis V., 529 Park av., Orange
Bender, Louis, 285 Ridgewood av., Newark
Bengelsdorf, Aron, 29 Clinton pl., Newark
Bensel, Arlington, Jr.,8 Bunny Circle,Newt'v'e,Mass.
Benz, George L., 251 S. Tenth st., Newark
Berardinelli, Carmine G., 92 Eighth av., Newark
Berg, Samuel, 156 Roseville av., Newark
Berger, William A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berlin, Morris R., 84 Girard pl., Newark
Berman, H. Robert, 299 Clinton av., Newark
Berney, Irving, 31 Lincoln Park, Newark
Berney, Ruth V., 16 Lyons av., Newark
Bernhard, William G., 79 Minninsink rd., Sh't Hills
Bernstein, Arthur, 89 Lincoln Park, Newark
Bernstein, Israel, 95 Wilson av., Newark
Bernstein, Julius, 584 S. Tenth st., Newark
Besson, Franklin J., 999 Clinton av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark
Binder, Charles I., 833 South 13th st., Newark
Bissett, John V., 29 Hawthorne av., East Orange
Biunno, Anthony J., 61 Hillcrest ter., East Orange
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 144 Harrison st., East Orange
Blasi, Benjamin, 150 Hunterdon st., Newark
Blasi, Clifford, 26 Longfellow av., Newark
Blaustein, Maurice L., 859 S. 13th st., Newark
Bleiberg, Jacob, 31 Lincoln Park, Newark
Block, Charles, 368 Clinton av., Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Block, Milton, 320 Union av., Irvington
Bocchini, Joseph A., 366 S. 12th st., Newark
Bokor, Emery, 819 S. 12th st., Newark
Bolten, Bernard, 377 Osborne ter., Newark
Bombardieri, Anthony, 251 Centre st., Nutley
Bonomo, Michael J., 587 S. Tenth st., Newark
Booken, Gerald J., 1 Johnson av., Newark
Borsher, Irving P., 306 Ridge st., Newark
Bosch, Donald T., 244 Woodside av., Ridgewood
Bove, Joseph, 306 Lincoln av., Orange
Bozzi, Robert, 406 Roseville av., Newark
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 26 N. Mountain av., Montclair
Bradley, Muriel, 126 Lorraine av., Up. Montclair
Brady, Frank J., 1038 S. Orange av., Newark
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Brams, William M., 7 Madison av., Newark
Brandman, Otto, 190 Clinton av., Newark
Braun, Gustav A., 269-A Harrison G'rd'ns, E.Orange
Bremer, Kenneth M., 85 S. Harrison st., E. Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne J. S., Edgemere Hotel, East Orange
Brinning, Elbert C., Jr., 442 Washington av., Moncl'r
Brizard, Joseph L., 81 High st., Belleville
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborne ter., Newark
Bromberg, Jules H., 89 Lincoln Park, Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Harold W., 27 S. Fullerton av., Montclair
Brown, Lewis W., 160 Roseville av., Newark
Browne, George F, 126 Lorraine av., Up. Montclair
Bruning, Richard H., 372 Wyoming av., Maplewood
Brunkow, Charles D., 31 Lincoln Park, Newark
Brunner, Hans, 670 Clinton av., Newark
Buchan, Ronald F., Prudential Insurance Co., New'k
Buckley, Jeremiah L., 666 Franklin av., Nutley
Buckner, Roscoe W. H., 20 Rose st., Newark
Buermann, August, III, 153 Irvington av., S. Orange
Bull, Louis M., 7 Brook Lane, Maplewood
Bull, William J., 98 Park st., Montclair
Burch, Reynold E., 102 S. 14th st., Newark
Burke, Leonard P., 76 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burnett, Lawrence F., 386 Roseville av., Newark
Burpeau, William P., 80 Woodland av., East Orange
Burrill, Benjamin B., Jr., 83 Park st., Montclair
Burstein, Frank, 1115 S. Broad st., Newark
Burstein, Leo Q., 115 Jefferson av., Elizabeth
Burstein, Rachel, 31 Lincoln Park, Newark
Busch, Herman, 32 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butan, Louis, 479 Highland av., Orange
Buvinger, Charles W., 50 Washington st., E. Orange
Byck, Louis, 794 S. 11th st., Newark
Byrne, Francis, Jr., 35 Park av., West Orange
Byrnes, Elizabeth W., 55 S. Maple av., East Orange
Bythewood, Alton E., Jr., 145 W. Market st.,Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Cagan, Maclyn, 60 Ridge rd., North Arlington
Caggiano, Anthony P., 137 Grove st., Montclair
Cahill, Laurence A., 361 Lafayette st., Newark
Calasibetta, Charles J., 37 Longfellow av., Newark
Caldwell, Donald M., 219 N. Arlington av., E. Orange
Caldwell, Julius A., 45 S. Mountain av., Montclair
Calvert, William C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Campbell, Everette L., 144 Harrison st., East Orange
Campbell, William, 144 Harrison st., East Orange
Cantalupo, Emidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 144 Harrison st.,EastOrange
Cappiello, William, 352 Seventh av., Newark
Caprio, Orlando G., 428 Third av., Newark
Caputo, Anthony R., 301 Washington av., Belleville
Carbone, Francesco N., 440 Central av., Orange
Cardwell, Edgar P., 965 Broad st., Newark
Carnrick, Millard, Jr., 14 Freeman st., Roseland
Carr, Josephus C., 75 13th av., Newark
Carrigan, Francis P., 305 Roseville av., Newark
Carrol, Wilfred, 51 Ingraham pl., Newark
Caruso, Anthony T., 304 Union av., Belleville
Cassini, Henry C., 27 Tremont av., East Orange
Castellano, Martin G., 330 Roseville av., Newark
Cerone, Daniel M., 365 Roseville av., Newark
Cestone, Canio, 1425 Pompton av., Little Falls
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark
Chamberlain, Richard R., 30 Lenox pl., Maplewood
Chernus, Jack, 61 Lincoln Park, Newark
Cheskin, Louis J., 31 Lincoln Park, Newark
Chiaramida, Joseph, Essex County Sana., Verona
Chiger, Alexander S., 621 High st., Newark
Chimacoff, Hyman, 159 Elizabeth av., Newark
Chmelnik, Abraham G., City Hospital, Newark
Christoph, Francis T., 959 Salem rd., Union
Chromow, Bernard, 95 Wilson av., Newark
Ciccone, Edwin L., 261 Roseville av., Newark
Cincotti, Victor, 11 Hill st., Newark
Citrino, Robert J., 345 Centre st., Nutley
Clarken, Joseph A., 27 Ingraham pl., Newark
Clement, Baxter L., 15 Washington st., Newark
Clinton, Joseph A., 339 Park av., Newark
Coburn, J. Wesley, 144 Harrison st., East Orange
Cockburn, Wilfred P., 48 East Kinney st., Newark
Coffin, Henry F., 116 N. Ninth st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Sidney L., 29 Girard pl., Newark
Cohen, Sidney P., 509 Franklin av., Nutley
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Coleman, Russell M., 76 N. Clinton st., East Orange
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood

Colton, Ethan T., Jr., 31 Park st., Montclair
Comando, Edward N., 695 Clinton av., Newark
Comando, Harry N., 695 Clinton av., Newark
Conlon, Philip J., 25 James st., Newark
Connamacher, Harold S., 671 Springfield av.,Newark
Conner, Herbert A., 222 Bastogne Sq., Newark
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Conti, Horace, Vet. Adm. Center, Biloxi, Miss.
Cook, Hugh F., 21 Roseville av., Newark
Cooperman, William, 647 Market st., Newark
Cornish, Charles H., 673 Prospect st., Maplewood
Cosulich, Livio, 181 Harding dr., South Orange
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
Covino, Louis L., 44 Oakland ter., Newark
Cox, John C., 55 Woodland rd., Maplewood
Cox, William W., 79 S. Fullerton av., Montclair
Cozzarelli, James J., 219 Belleville av., Belleville
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp.,CedarGrove
Craster, Charles V., Plane & William sts., Newark
Crater, Kenneth E., 172A Davey st., Bloomfield
Crawford, Georgina U., 65 Prospect st., E. Orange
Crecca, Anthony D., 376 Roseville av., Newark
Crecca, Joseph V., 115 S. Centre st., South Orange
Crecca, William D., 111 Park av., Newark
Cregar, John S., 440 S. Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., East Orange
Crunden, Allan B., Jr., 21 Plymouth st., Montclair
Crystell, Edward H., 4 Hawthorne av., Nutley
Cucinella, Anthony B., 361 Lafayette st., Newark
Cuono, Joseph D., Essex County Sana., Verona
Cupaiuoli, Richard A., 30 Lenox pl., Maplewood
D'Addario, Anthony R., 132 Broadway, Newark
D'Agostini, Alfred J., 41 Columbia av., Newark
D'Agostini, Robert J., 41 Columbia av., Newark
Dailey, Edward S., 141 Connett pl., South Orange
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Alesandro, Genesio L., Army
D'Ambola, Philip R., 21 S. Sixth st., Harrison
D'Amico, Thomas V., 70 Fairview av., Verona
Dane, Charles, 163 Kilburn pl., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Joseph C., 334 Washington av., Belleville
Dann, Frederick J., 65 Girard pl., Newark
Dante, Pasquale, 393 Millburn av., Millburn
Danzis, Louis, 863 S. 12th st., Newark
Danzis, Maximillian, 31 Lincoln Park, Newark
Darden, Walter T., 149 W. Kinney st., Newark
Daron, Simeon, 31 Lincoln Park, Newark
Davidson, Eric W., 290 Park st., Upper Montclair
Davidson, Maurice M., 128 Grant av., E., Roselle Pk.
Davies, George W., 35 Fairview av., Verona
Davis, John, 10 Washington st., Bloomfield
Davis, Louis, 825 S. 10th st., Newark
Davis, Thomas C., 30 Old Short Hills rd., Millburn
Davis, William A., 270 Ridgewood av., Glen Ridge
Davis, William J., 144 Harrison st., East Orange
Dear, Abraham L., 23 Synott pl., Newark
DeFilippis, Ralph L., 228 Tremont av., Orange
DeFronzo, Morando, 180 Fairmount av., Newark
DeGerome, James H., 10 Ridgewood av., Glen Ridge
DeHart, George K., 132 Sunset av., Verona
Deignan, William L., 257 Dodd st., East Orange
Delatusch, George A., 180 Park st., Montclair
Del Deo, Nicholas V., 49 State st., Newark
DeLeonardis, James V., 94 Jefferson st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
DeLia, Emilio, 25 Crane st., Newark
Della Ragione, Mario, 120 Second av., Newark
Del Negro, Albert E., 402 Roseville av., Newark
DeLorenzo, Francis, 281 Bellevue av., Montclair
DeMichele, Roland V., 516 Clifton av., Newark
Denes, Oscar, 402 Centre st., Nutley
Dennison, Alfred D., Jr., 601 Ridgew'd rd., Maplew'd
DePhillips, Benedict R., 297 Mt. Prospect av., New'k
DeTroia, Frederick C., 26 Stanley rd., South Orange
Deutel, Oscar R., 265 Newark av., Bloomfield
DeVincentis, Henry, 285 Henry st., Orange
Devlin, Arthur D., 138 Isabella av., Newark
Devlin, Hugh J., 72 Thomas st., Newark
deVries, John K., 144 Harrison st., East Orange
Dewis, Edwin G., 21 Westra st., Interlaken
Dicker, Ralph L., 31 Lincoln Park, Newark
Dieffenbach, Richard H., 570 Mt.Prosp't av.,Newark
Diener, Samuel, 14 Clinton pl., Newark
DiFino, Felix J., 172 Edison pl., Newark
DiGiacomo, Harry E., 195 Hunterdon st., Newark
DiGiacomo, William H., 223 Fairmount av., Newark
DiLeo, Victor, 453 Park av., Orange
Dinge, Ferdinand C., 67 S. Munn av., East Orange
DiNorcia, Joseph, 498 W. Market st., Newark
Dmytriw, Stephen, 226 N. Park st., East Orange
Donchi, Sol M., 118 Oakview av., Maplewood
Donnelly, John H., 634 S. 20th st., Newark
Douglass, Frederick W., 160 Lincoln st., Montclair
Dranow, Paul, 233 Franklin av., Nutley
Drapkin, Berta, 31 Lincoln Park, Newark
Dreizin, David, 201 Lyons av., Newark
Dreskin, Jacob L., 34 Lyons av., Newark
Drewniany, Bernardine, 461 Kingsland av., Lyndh'st
Duffy, Edward P., Jr., 379 Washington av., Belleville
Duffy, William J., 22 Nairn pl., Newark
Dulany, Theodore L., 170 W. Market st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
Dunn, Theodore B., 35 Park pl., Bloomfield
Durchlag, E. Nelson, 60 Myrtle av., Irvington
Dwork, Harold K., 1 Hansbury av., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark
Eck, Daniel B., 144 Harrison st., East Orange
Eckhardt, Janet L., 120 Prospect st., South Orange
Edelen, James J., 100 S. Munn av., East Orange
Edelson, Edmond, 127 Lehigh av., Newark
Edwards, Sydney K., 52 Lexington dr., Livingston
Ehrlich, Edward, 838 S. 13th st., Newark
Ehrlich, William E., 31 Lincoln Park, Newark
Eichler, Bernard B., 221 Midland av., Montclair
Ein, William B., 31 Lincoln Park, Newark
Einhorn, Harvey, 241 16th av., Newark
Einhorn, Samuel E., 241 16th av., Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Eisenstodt, Lester W., 31 Lincoln Park, Newark
Ellis, Arthur J., 140 Roseville av., Newark
Emmer, S. Wolfe, 31 Lincoln Park, Newark
English, John T., 110 Yale av., Irvington
Epstein, Harry B., 31 Lincoln Park, Newark
Epstein, William M., 322 E. Westfield av., Roselle P.
Erdman, George L., 50 Cedar st., Maplewood
Erler, Robert E., 360 Prospect st., South Orange
Ervin, Millard B., 36 Canterbury lane, Westfield
Etheridge, Charles H., 433 Prospect st., East Orange
Evans, Charles H., 144 Harrison st., East Orange
Evans, David P., 144 Harrison st., East Orange
Evans, John R., Jr., 496 Prospect st., Maplewood
Ewing, Harvey M., 31 Trinity pl., Montclair
Fader, Ferdinand, 350 Springdale av., East Orange
Fager, Rudolph O., 53 Park pl., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fain, Irving, 155 Chancellor av., Newark
Farb, Harry H., 21 Clinton pl., Newark
Fasano, Giovanni, 194 S. Seventh st., Newark
Fava, Philip V., 646 Sanford av., Newark
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Feinsod, Samuel N., 1305 Clinton av., Irvington
Feldman, Frank H., 115 Lyons av., Newark

Fendrick, Edward, 17 Watson av., East Orange
Ferguson, William E., Newark City Hosp., Newark
Fern, Samuel S., 122 Elizabeth av., Newark
Fernicola, Anthony R., 565 Mt. Prospect av.,Newark
Feuer, Joseph A., 59 Seeley av., Arlington
Fink, A. Elston, 489 High st., Newark
Fink, Irving E., 71 Lincoln Park, Newark
Finkel, Joshua, 853 S. 11th st., Newark
Finkelstein, Aaron, 762 S. Tenth st., Newark
Finkelstein, Abe S., 670 Clinton av., Newark
Finkler, Rita S., 35 Leslie st., Newark
Finnerty, Urban R., St. Vincent's Hospital, Montcl'r
Fischbein, Martin M., 976 Sanford av., Irvington
Fischer, David D., 35 Goldsmith av., Newark
Fischer, Louise, 31 Lincoln Park, Newark
Fischman, Harold H., 326 Avon av., Newark
Fissell, George M., 140 Roseville av., Newark
Fitzgerald, Robert, 32 Johnson av., Newark
Flanagan, James F., 195 Elwood av, Newark
Flanagan, John J., 173 Roseville av., Newark
Flax, Jacob L., 31 Lincoln Park, Newark
Fleischmann, Viola G., 103 Scotland rd., S. Orange
Fleming, Joseph A., 247 Claremont av., Montclair
Flicker, David J., 82 Clinton av., Newark
Floody, Robert J., 324 Kingsland st., Nutley
Flower, Morrie A., 39 Lincoln Park, Newark
Flynn, Edward A., 176 Washington av., Belleville
Foley, James F., 344 N. Grove st., East Orange
Fonda, Gerald E., 6 Parkview dr., Millburn
Forte, Daniel L., 545 Central av., Orange
Forte, Frank S., 318 Roseville av., Newark
Fortunato, Joseph F., 349 Walnut st., Newark
Fortunato, Samuel J., 90 Kenwood pl., E. Orange
Fost, William H., 107 Franklin st., Belleville
Fowler, Royale H., 744 Broad st., Newark
Frame, Dorothy L., 15 Highland av., Glen Ridge
Francy, Donald G., 314 Stuyvesant av., Lyndhurst
Frank, Geza M., 56 Hedden ter., Newark
Frank, Simon C., 62 Ridge rd., North Arlington
Frank, Ulysses M., 12 Undercliff rd., Millburn
Franklin, Frank A., 256 S. Centre st., Orange
Fratantuno, Michael J., 14 Vermont av., Newark
Freeman, George C., Prudential Ins. Co., Newark
Freinkel, Jacob, 2 Hillside av., Newark
Friedman, Harry, 721 S. 16th st., Newark
Friedman, Hyman, 1096 Sanford av., Irvington
Friedrich, Adam H., 47 Clark st., Manasquan
Froelich, Jerome J., 74 Ingraham pl., Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
Fruchtbaum, Robert P., 431 Franklin av., Nutley
Fullilove, Robert E., Jr., 24 Waverly av., Newark
Furman, Benjamin A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
Furst, William, 188 Clinton av., Newark
Galloto, Frank M., 188 Ampere Parkway, Bloomfield
Gamba, Joseph, 388 Fairmount av., Newark
Gambacorta, Leopoldo, 397 N. 13th st., Newark
Gambacorta, Otto, 98 Broad st., Bloomfield
Gamsu, George, Army
Ganley, Arthur J., 390 Park av., East Orange
Ganot, Frank I., 392 Ridge st., Newark
Gardam, Joseph W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gaugier, Louis C., 85 Up. Mountain av., Montclair
Gaydos, Albert, 225 Hillside av., Nutley
Gaylor, Earl L., Jr., 85 S. Harrison st., East Orange
Geannette, Ernest D., 14 Harrison av., Montclair
Gehl, Raymond H., 114 Lyons av., Newark
Gehl, Sidney H., 83 Wolcott ter., Newark
Gelb, Jerome, 86 W. Alpine st., Newark
Geller, Samuel, 696 High st., Newark
Gencher, Benjamin, 33 Park av., Caldwell
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
Gerard, Patrick D., 364 Roseville av., Newark
Gerhardt, Paul E., 718 S. 17th st., Newark
German, Bernard, 89 Lincoln Park, Newark
Gershenfeld, David B., 73 Shanley av., Newark
Giannotto, Anthony S., 403 S. 10th st., Newark
Gianquinto, Peter, St. Barnabas Hospital, Newark
Giardina, John S., 321 Walnut st., Newark
Giardina, Vincent J., 102 Jefferson st., Newark
Gibson, Augustus, Mendham
Giffoniello, Arthur A., 334 Roseville av., Newark
Gifford, William R., 247 Park av., East Orange
Gillespie, John L., 26 Midland av., Arlington
Gilman, Leonard, 6 S. Fullerton av., Montclair
Ginsberg, Leon, Essex County Hosp., Cedar Grove
Giuffra, Frank, 161 Park st., Montclair
Giuliana, Robert A., 31 Central av., Newark
Glass, Oscar, 838 S. 12th st., Newark
Glass, William H., 144 Harrison st., East Orange
Glazier, Jesse T., 670 Sanford av., Newark
Gluckman, Saul K., 78 Johnson av., Newark
Glynn, S. Robert, 54 Girard pl., Newark
Godfrey, Alan O., 231 Roseville av., Newark
Goeller, Jacob D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Bernard R., 190 Clinton av., Newark
Goldberg, Harold H., 814 S. Tenth st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., W. Orange
Golden, Clement H., 30 Myrtle av., Irvington
Goldman, Jerome, 1 Johnson av., Newark
Goldman, Lester M., 53 Leslie st., Newark
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goodman, Kenneth, 141 Park av., East Orange
Goodman, Stanley J., 89 Lincoln Park, Newark
Gordon, A. Julius, 140 Roseville av., Newark
Gorten, Manfred L., 669 Elizabeth av., Newark
Grant, Francis, 1224 Salem av., Hillside
Grant, William F., 309 Roseville av., Newark
Gras, Alfred E., 140 Roseville av., Newark
Grasso, Anthony P., Army
Gray, John W., 142 Clinton av., Newark
Green, Henry, 89 Lincoln Park, Newark
Greenberg, Jacob L., 189 16th av., Newark
Greenberg, Nathan H., 29 Osborne ter., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greene, Richard W., 32 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Greenfield, Herbert, 31 Lincoln Park, Newark
Greenfield, Leonard S., 691 Clinton av., Newark
Greenfield, Sylvan J., 32 S. Munn av., East Orange
Greenwald, Eugene, 100 Hollywood av., Hillside
Greenwald, Theo. L., 44 Maple av., Morristown
Greenwood, Samuel B., 190 Clinton av., Newark
Greer, Melvin A., 190 Washington st., Bloomfield
Gregory, Mildred G., 64 N. Ninth st., Newark
Greifinger, Marcus H., 31 Lincoln Park, Newark
Greifinger, William, 22 Vassar av., Newark
Griffin, Guy B., 208 South Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Gross, Irving, 16 Grove av., Verona
Grossblatt, Philip, 31 Lincoln Park, Newark
Gruber, William L., 8820 Murietta av.,VanNuys,Cal.
Grubin, Charles J., 1410 Maple av., Hillside
Grubin, Harold, 690 Clinton av., Newark
Grundfest, Jack, 659 Kearny av., Arlington
Grundfest, Philip, 53 Kearny av., Kearny
Grundorfer, Joseph, 201 Lyons av., Newark
Grunt, Louis, 190 Clinton av., Newark
Gulick, James B., 363 Carteret pl., Orange
Gullord, Edward G., 21 Trinity pl., Montclair
Gutowski, Walter T., 104 Grove ter., Irvington
Hagman, Frank E., Army
Hahn, Katherine B., 372 Thornden st., South Orange
Hahn, William H., 198 Clinton av., Newark

Haley, Paul W., 719 Sanford av., Newark
Haller, Olga, 182 Roseville av., Newark
Halprin, Harry, 145 Union st., Montclair
Hamilton, Robert G., 100 Main st., Orange
Hanan, James T., 11 The Crescent, Montclair
Hand, Frederick G., 119 Irvington av., So. Orange
Hanfling, Seymour L., 115 S. Munn av., E. Orange
Hansen, Harold T., 153 Irvington av., South Orange
Hantman, Harold, 196 Roseville av., Newark
Harden, Albert S., 510 W. Market st., Newark
Harden, Albert S., Jr., 551 Ridgewood rd., Maplew'd
Harms, Charles R., 363 Park st., Montclair
Harris, Jonathan L., 1060 Broad st., Newark
Harris, Leonard, 299 Clinton av., Newark
Harris, Morris, 102 Broad st., Bloomfield
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Harvey, Robert K., 711 Kearny av., Arlington
Harvey, Thomas W., 59 Main st., Orange
Haschec, Walter, 690 S. 19th st., Newark
Hasney, Frederick A., 118 Main st., West Orange
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, William H., 644 Stuyvesant av., Irvington
Hawkes, E. Zeh, 161 Roseville av., Newark
Hawkes, Stuart Z., 161 Roseville av., Newark
Hayes, Gerald W., 86 Hawthorne av., East Orange
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 494 Belgrove dr., Arlington
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, Carye-Belle, 202 Clinton av., Newark
Hennig, Paul F., 688 Stuyvesant av., Irvington
Henshaw, George R., 228 Midland av., Montclair
Hermann, John H., 197 S. Centre st., Orange
Hermann, John H., Jr., 197 S. Centre st., Orange
Herndon, Lewis S., 144 Harrison st., East Orange
Hertzberg, Irving, 586 Kearny av., Kearny
Hewson, George F., 21 Roseville av., Newark
Heyman, Arthur, 89 Lincoln Park, Newark
Heyman, Jacob, 846 S. 12th st., Newark
Hicks, Alfred M., 149 Park st., Montclair
Higgins, Eugene V., 1180 Raymond Blvd., Newark
Hill, Arthur G., 324 Grove st., Montclair
Hill, James O., 84 Barclay st., Newark
Hill, Robert H., 227 Roseville av., Newark
Hillman, Ernest C., Jr., 300 Broadway, Newark
Hilton, Clarence O., 556 N. Seventh st., Newark
Hinckley, Livingston S., 182 Clinton av., Newark
Hirsch, Theodore, 842 S. 13th st., Newark
Hitschmann, Otto B., 97 Lincoln Park, Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holder, Lester, 1750 Walker av., Union
Holderith, Albert E., 15 Virginia av., Livingston
Holmes, George J., 17 Elizabeth av., Newark
Holtz, Harry M., 299 Clinton av., Newark
Hooton, Thomas C., 31 Trinity pl., Montclair
Hopping, Richard A., 15 Washington st., Newark
Horland, Aaron H., 37 Chancellor av., Newark
Horn, Harry, 622 Stuyvesant av., Irvington
Horn, Helen A., Mountainside Hospital, Montclair
Horn, Max, 850 S. 11th st., Newark
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Hubach, Maximilian F., Jr., 307 M'tg'mry st., Blmfd.
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Huber, William H., 587 Prospect st., Maplewood
Huberman, John, 853 S. 12th st., Newark
Huberman, Victor, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., East Orange
Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 671 Broad st., Newark
Hyde, Robert T., Navy
Hyland, Michael, 197 Kearny av., Kearny
Hymes, Ben, 66 Baldwin av., Newark
Iatesta, Matthew, 60 Northfield av., West Orange
Ill, Edmund W., 477 Mt. Prospect av., Newark
Ill, Herbert M., 42 Woodland av., Glen Ridge
Inge, Hutchins F., 205 So. Orange av., Newark
Insabella, John, 317 S. Orange av., Newark
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Israel, Joseph, 252 Washington av., Belleville
Israeloff, Howard H., 1038 Clinton av., Irvington
Jackson, George H., 100 Elmwood av., Union
Jacobs, Benjamin, 1612 Clinton pl., Hillside
Jacobs, William, 1030 Stuyvesant av., Irvington
Jaeckle, Charles E., 136 Evergreen pl., East Orange
James, Bart M., 15 Washington st., Newark
Jarvis, Daniel G., 31 Lincoln Park, Newark
Jaso, James V., 710 Varsity rd., South Orange
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Jenkins, R. Jewett, 683 High st., Newark
Jennings, Robert E., 117 Washington st., E. Orange
Johnson, Robert A., 68 Roseville av., Newark
Jonitz, Robert, 153 S. Grove st., East Orange
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Kahrs, Grace M., 311 Mt. Prospect av., Newark
Kalb, S. William, 416 Clinton pl., Newark
Kalter, George E., 640 Prospect st., Maplewood
Kaney, Emil M., 74 Clinton av., Newark
Kaplan, Elliot L., 251 Meeker av., Newark
Katzin, Eugene M., 50 Baldwin av., Newark
Kauder, Warren G., 201 Lyons av., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kavanaugh, Daniel E., 566 Mt. Prospect av.,Newark
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Kearney, Edward P. J., 83 S. Fullerton av., Montclair
Kearney, John F., 238 Hilton av., Maplewood
Kearney, Paul A., 12 Woodcraft pl., Short Hills
Keats, Sidney, 31 Lincoln Park, Newark
Keim, William F., Jr., 15 Washington st., Newark
Kelemen, Nicholas M., 315 Central av., East Newark
Kempe, George, 963 Caldwell av., Union
Kennedy, William M.,413 N. Main st.,Morresv'le,N.C.
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Kern, E. Clarence, 45 Park st., Montclair
Kern, Meyer J., 144 Clinton av., Newark
Kesselman, Samuel R., 29 Stratford pl., Newark
Kessler, Henry B., 40 Clinton pl., Newark
Kessler, Henry H., 53 Lincoln Park, Newark
Keyssar, Alexander, 18 Isabella av., Newark
Kiessling, Charles E., 763 Broad st., Newark
Kieswetter, Dayton T., 75 Prospect st., East Orange
Kiley, John E., 94 Park st., Montclair
Kimche, Irwin, 37 Rawley pl., Millburn
Kimmel, Charles, 488 Broad st., Bloomfield
Kinley, John W., 111 Clinton av., Newark
Kirkman, Leroy G., 176 Roseville av., Newark
Klein, Andrew J. V., 94 Hawthorne av., E. Orange
Klein, Edward C., Jr., 73 Lincoln Park, Newark
Klein, Michael, 1540 Spring Val. dr.,Hunt'gt'n,W.V.
Kleinman, Maurice, 101 Clinton av., Newark
Klenk, Joseph P., 328 Belleville av., Bloomfield
Kline, George L., 519 Mt. Prospect av., Newark
Klosk, Emanuel, 324 Radel ter., South Orange
Klostermyer, Louis L., Mountainside Hosp., Montcl'r
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Koeck, George P., 305 Roseville av., Newark
Kohn, Leo, 86 Park pl., South Orange
Kollmar, Robert, 617 W. 168th st., New York City
Kolodin, Abraham, 185 Broad st., Bloomfield
Koralek, Adolph H., 31 Lincoln Park, Newark
Kornfeld, Werner, 645 Central av., East Orange
Kosterlitz, Henry H., 640 Stuyvesant av., Irvington

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Kraker, David A., 31 Lincoln Park, Newark
Krichbaum, Carroll E., Army
Krone, William F., 31 Lincoln Park, Newark
Krug, Alfred J., 1460 Clinton av., Irvington
Kruger, William, 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark
Kunz, Harold G., 64 Hawthorne pl., Montclair
Kuperman, Henry L., 79 Baldwin av., Newark
Kyhos, Emma D., 314 Hillside av., Nutley
Lafferty, Elton B., 69 Orange av., Irvington
Landesman, William, 187 Kearny av., Kearny
Langgaard, Charles, City Hospital, Newark
Larkey, Irving G., 95 Shanley av., Newark
Leaman, Granville M., 182 N. Grove st., E. Orange
Le Bel, Louis J. B., 165 Grant av., Nutley
Leber, Otto H., 63 Myrtle av., Montclair
Lee, John J., 309 Park av., Orange
Lee, Robert E., 24 Great Oak drive, Short Hills
Leeds, Leonard W., 701 Stuyvesant av., Irvington
Leff, Abraham, 98 Hackensack st., Wood-Ridge
Leff, Charles O., 5 Elm Court, South Orange
Leff, William A., 299 Clinton av., Newark
Lehman, David J., Jr., 192 Roseville av., Newark
Lemkin, Samuel, 71 Pomona av., Newark
Leon, Maurice J., 387 Up. Mountain av., Up. Montcl'r
Levin, Joseph, 831 S. 13th st., Newark
Levin, Murray, 20 Callamore dr., West Orange
Levine, Burton, 31 Lincoln Park, Newark
Levine, Edward P., 384 Clinton av., Newark
Levine, Philip, 61 Lincoln Park, Newark
Levinson, David M., 860 S. 12th st., Newark
Levinson, Louis J., 43 S. Pierson rd., Maplewood
Levison, William, 75 Lincoln Park, Newark
Levy, Anna L., 32 S. Munn av., East Orange
Levy, Julius, 221 S. Harrison st., East Orange
Lewandowski, Edmund E., 2 Smalley ter., Irvington
Lewis, G. Rae, 458 Washington av., Belleville
Liccese, Emanuel, 84 Jefferson st., Newark
Licks, Frederick C., 64 Scotland rd., So. Orange
Lieb, Robert L., 61 Lincoln Park, Newark
Lieb, Saul, 90 Treacy av., Newark
Liegner, Ben, 858 S. 12th st., Newark
Lilien, Bernard B., 1191 Clinton av., Irvington
Lilien, Milton, 1191 Clinton av., Irvington
Linz, Curt, 456 Franklin av., Nutley
Lippman, Harold, 68 Elizabeth av., Newark
Lipstein, William, 845 Chancellor av., Irvington
Livingston, Bernard, 30 Park av., Caldwell
Livingston, Elias, 591 Stuyvesant av., Irvington
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis H., 188 Clinton av., Newark
Lohman, Herman, 31 Lincoln Park, Newark
Lombardo, Bartlo, 111 Wilson av., Newark
Long, John F., 82 Grand pl., Arlington
Longo, James J., 74 Ridge rd., N. Arlington
Lovell, John F., 1013 Clinton av., Irvington
Lowenstein, Aaron, 860 S. 11th st., Newark
Lowenstein, Harry A., 96 Milford av., Newark
Lowrey, James H., 79 Congress st., Newark
Luban, Benjamin, 730 High st., Newark
Lundblad, Walter E., 75 Prospect st., East Orange
Luongo, Federico, 212 S. Centre st., Orange
Lurie, Solomon I., 21 Hillside av., Newark
Lurie, Wolf, 379 Kearny av., Kearny
Lustig, Melvin, 227 Schuyler av., Newark
Lutz, William M., 3 Southern Slope dr., Millburn
Lynch, Albert E. O., 257 Orange rd., Montclair
Lyon, Archibald, 115 Ridge rd., North Arlington
Lyons, James V., 333 Park av., Orange
Maas, Max A., 329 Clinton av., Newark
Macaluso, Dominic C., 452 Washington av.,Belleville
MacArt, J. Harold, 120 Prospect st., South Orange
MacArthur, Clymont, 219 Roseville av., Newark
MacMillan, C. Wright, 4 Duryea rd., Up. Montclair
Macpherson, Elwood H., 34 Rawley pl., Millburn
Maffeo, Carl E., 266 Van Buren st., Newark
Maggio, George A., 419 Roseville av., Newark
Maggio, Nicholas A., 130 Fleming av., Newark
Magovern, Thomas F., 228 S. Orange av., S. Orange
Mahood, Herbert L., 86 Durand rd., Maplewood
Maisel, Irving, 112 Chapman pl., Irvington
Malgeri, John, 279 Shepard av., East Orange
Mamlet, Alfred M., 33 Johnson av., Newark
Mancusi-Ungaro, Alvin P.,268 Mt.Prospect av.,N'w'k
Mancusi-Ungaro, Harold, 480 Grove st., Montclair
Mancusi-Ungaro, Lodovico, 156 Mt. Pr'sp't av.,Nwk.
Manfro, Gerard J., 35 Newark St., Newark
Marcus, Donald, 647 Stuyvesant av., Irvington
Margolis, Alfred, 736 Sanford av., Newark
Margulies, Charles, 49 Park dr., Nutley
Marin, Robert B., 85 Park st., Montclair
Marks, Zelda I., 202 Clinton av., Newark
Marquis, Dean W., 144 Harrison st., East Orange
Marquis, W. James, 12 Hawthorne av., E. Orange
Marra, Rocco S., 221 Park av., Orange
Martland, Harrison S., City Hospital, Newark
Marucci, Horace D., 298 Elmwood av., Maplewood
Masciocchi, Thomas A., 316 Park av., Orange
Mason, Virgil A., 144 Harrison st., East Orange
Massengill, Fulton, 233 Heywood av., Orange
Masterson, John F., 98 Myrtle av., Irvington
Matheke, George A., 29 E. Wood st., East Orange
Matheke, Otto G., 328 Sussex av., Newark
Matheke, Otto G., Jr., 328 Sussex av., Newark
Matheson, Gilchrist E., 144 Harrison st., E. Orange
Matthews, Clifford B., 1180 Raymond Blvd., Newark
Matthews, William F., 180 Walnut st., Montclair
Mauer, Richard E., 116 Ridge rd., Rutherford
Maurer, K. Virginia, 16 Prospect rd., Livingston
May, Ernst A., 52 De Forest av., Summit
Mazur, Stephen H., 557 Grove st., Irvington
McAveney, Thos. F. G., 58 N. Munn av., East Orange
McCarroll, E. Mae, 59 Hillside pl., Newark
McCauley, Francis J., 140 Roseville av., Newark
McCormick, James E., 775 Elizabeth av., Newark
McCroskery, Hamilton M., 471 N. Arlington av., E.O.
McCroskery, James H., 471 N. Arlington av., E. O.
McGeary, John A., 31 Lincoln Park, Newark
McGuinn, William B., 10 N. Ridgew'd rd., S. Orange
McGuire, John J., 2 Gould av., Newark
McGurl, Francis J., 763 Broad st., Newark
McKeown, George H. C., 68 Mont'ne st., Br'kl'n,N.Y.
McKim, William F., 317 Roseville av., Newark
McLaughlin, William B., 120 Branch Br. dr.,Bellev'le
McLellan, George A., 19 Hawthorne av.,East Orange
McVay, Edward A., 234 Lafayette st., Newark
Mearin, Robert J., 24 Porter pl., Montclair
Meehan, Martin M., 339 Washington av., Belleville
Meinhard, Fred, 154 Van Buren st., Newark
Meisel, David B., 818 S. 12th st., Newark
Mele, Vincent, 268 Prospect st., South Orange
Mellen, Stanley H., 1 Park pl., Bloomfield
Menk, Paul E., 31 Lincoln Park, Newark
Merk, Anthony, 79 N. Ninth st., Newark
Merkelbach, Walter P., 288 Broad st., Bloomfield
Merliss, Eugene, 299 Clinton av., Newark
Mermod, Camille, 15 Washington st., Newark
Merrick, Evelina, 142 Clinton av., Newark ,
Mersells, John G., 110 Irvington av., South Orange
Messina, Thomas, 128 Park av., East Orange
Metsky, Joseph, 777 High st., Newark
Meurlin, Alfred, 144 Harrison st., East Orange
Mick, Edwin C., 46 S. Burnett st., East Orange
Miller, Eugene L., 63 Baldwin av., Newark
Miller, Herman P., 815 S. 12th st., Newark
Miller, I. Irwin, 675 Sanford av., Newark

Miller, Joseph A., 364 Prospect st., South Orange
Miller, Nathan, 838 S. 12th st., Newark
Miller, Ralph, 32 Johnson av., Newark
Minier, Carl L., 226 N. Park st., East Orange
Miningham, William D., 18 Hedden ter., Newark
Minnefor, Charles A., 1164 S. Orange av., S. Orange
Mitchell, Augustus J., 270 Montclair av., Newark
Mitchell, Walter L., Jr., 161 Roseville av., Newark
Modeski, Chester J., 306 Roseville av., Newark
Moeckel, Clarence W., 63 S. Fullerton av., Montclair
Monaco, Dante P., 436 Roseville av., Newark
Monaco, Saverio A., 293 Camden st., Newark
Monte, Thomas D., 213 Park st., Montclair
Moore, Dean C., 391 Highland av., Orange
Moress, Edward J., 1524 Maple av., Hillside
Morgan, Browne, 32 Benson st., Bloomfield
Morton, Thomas V., Jr., 263 Bloomfield av., Bl'mfield
Motzenbecker, Peter F., 69 S. Pierson rd., Maplewood
Motzenbecker, William J., 16 Milford av., Newark
Mulberg, Harry, 769 Kearny av., Arlington
Murphy, Thomas W., Jr., Navy
Murray, Edward F., 140 Roseville av., Newark
Murray, Harrold A., 624 Mt. Prospect av., Newark
Nacca, Carl A., 46 Cleveland st., Orange
Nadel, Charles I., 1013 Clinton av., Irvington
Napoliello, Vincent, 125 Clifton av., Newark
Nappi, Pasquale E., 433 Mt. Prospect av., Newark
Nash, Alexander E., 30 Forrest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nataro, Jerome D., Army
Nataro, Joseph, 172 Littleton av., Newark
Nataro, Maurice, Nichols Gen. Hosp., Louisville,Ky.
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Nelson, Clifford H., 200 Isabella av., Irvington
Nelson, Richard A., 763 Broad st., Newark
Nemzek, William P. B., 8 Hedden ter., N. Arlington
Nevius, William B., 572 Park av., East Orange
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 318 Highland rd., South Orange
Ney, J. Marshall, 443 Baldwin rd., Maplewood
Nichols, Joseph E., 144 Harrison st., East Orange
Nicola, Toufick, 96 Gates av., Montclair
Noll, Louis, 1383 Clinton av., Irvington
Novak, John G., 111 Clinton av., Newark
Novich, Max, 1484 Liberty av., Hillside
Nussbaum, Harvey E., 695 Clinton av., Newark
Nutzel, Leon P., Army
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Oberlander, Gertrude, 866 S. 13th st., Newark
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O'Connor, Dennis F., 27 S. Kingman rd., S. Orange
O'Connor, Michael J., 98 Shanley av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
O'Grady, Michael J., 330 Washington av., Belleville
Olini, Joseph J., 30 W. Market st., Newark
O'Lini, Louis J., 30 W. Market st., Newark
O'Neill, Charles L., 11 N. Seventh st., Newark
O'Neill, Charles L., Jr., 671 Broad st., Newark
Onorato, Vincenzo R., 66 Christopher st., Montclair
Opdyke, Gordon M., 52 Claremont av., Verona
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Orris, Harold J., 80 Chancellor av., Newark
Orton, Henry B., 224 Delavan av., Newark
Ostrowski, Sigismund J., 265 Broad st., Bloomfield
Ott, Franklin B., 999 Clinton av., Irvington
Outwin, Richard N., 46 Maple st., Maplewood
Paddock, Royce, 965 Broad st., Newark
Padovano, Joseph, 517 Roseville av., Newark
Palmer, Henry S., 128 Court st., Newark
Panitch, William, 90 Baldwin av., Newark
Pannell, Walter L., 100 Evergreen pl., E. Orange
Pannullo, John N. P., 365 Roseville av., Newark
Panzer, Norman, 615 High st., Newark
Papera, John J., 8 Washington pl., Caldwell
Parell, George C., 275 S. Seventh st., Newark
Parent, Sol, 89 Lincoln Park, Newark
Parker, John E., 385 Park av., Orange
Parkes, Morey, 33 High st., Orange
Parsonnet, Aaron E., 3 Madison av., Newark
Parsonnet, Eugene V., 89 Lincoln Park, Newark
Pascall, Thomas M., 197 Lincoln av., Newark
Pattyson, Ralph A., 144 Harrison st., East Orange
Paul, George A., 788 Lyons av., Irvington
Paul, H. Carl, 30 Westville av., Caldwell
Pavia, John R., 48 Mountainview av., East Orange
Payne, Guy, Jr., 56 S. Prospect st., Verona
Pecora, Samuel, 599 Mt. Prospect av., Newark
Pedicini, Joseph L., 588 S. Tenth st., Newark
Peer, Lyndon A., 15 Washington st., Newark
Pellecchia, Leonard J., 109 Parker st., Newark
Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pendexter, Sidney E., Jr., 11 S. Arlington av., E. O.
Pentecost, Salvador D., 14 Clarem't av., Maplewood
Peppard, Stanley H., 51 13th av., Newark
Perelman, Julius S., 94 Shanley av., Newark
Perham, Bertram S., 199 Lorraine av., Up. Montclair
Perlman, Maximilian, 188 High st., Nutley
Perlmutter, Irving K., 88 Clinton av., Newark
Permison, Michael, 1735 Stuyvesant av., Union
Perrone, Anthony J., 456 Roseville av., Newark
Petrone, Peter A., 81 Roseville av., Newark
Petry, William, 109 Treacy av., Newark
Phillips, Algernon A., 212 W. Market st., Newark
Picardi, Armand A., 256 Littleton av., Newark
Piegari, Felix H., 111 Mt. Pleasant av., Newark
Pilloni, Louis, 91 Beach st., Bloomfield
Pinto, Joseph A., 50 N. 11th st., Newark
Pizzi, Francis W., 205 Park av., Orange
Pizzi, Mario V., 205 Park av., Orange
Pois, John, 67 Scotland rd., South Orange
Poleshuck, Rubin, 100 Hollywood av., Hillside
Poller, Frederick K., 681 Stuyvesant av., Irvington
Pollis, Nicholas L., 642 High st., Newark
Pollock, Samuel L., 365 E. Schley st., Newark
Polow, Benjamin, 200 Clinton av., Newark
Pomerantz, Samuel, 9 Madison av., Newark
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Powers, Robert W., 205 Park st., Montclair
Probst, Everett W., 276 Willow av., Lyndhurst
Proctor, Jesse E., 15 N. 13th st., Newark
Provenzano, Samuel, 317 S. Tenth st., Newark
Quad, Clifford W., 52 Northfield av., West Orange
Quinn, Edward D., 323 Belleville av., Bloomfield
Rabinowitz, Jacob H., 35 Randolph pl., Newark
Rachal, Hurve J., 15 Wallace st., Newark
Rachlin, Harry T., 396 Union av., Irvington
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Rathgeber, Charles F., 18 William st., East Orange
Rattenne, Edward 549 Mt. Prospect av., Nowark
Ravitz, Samuel F., Army
Rawitz, Sidney B., 42 Chancellor av., Newark
Reeve-Allen, Jane, 42 Gordonhurst av., UpperM'tcl'r
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Reich, Henry, 89 Lincoln Park, Newark
Reich, Mortimer, 705 Elizabeth av., Newark
Reilly, Christopher J., 331 13th av., Nowark
Reinartz, Paul V., 763 Broad st., Newark
Reinfeld, Abraham G., 354 Clinton av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
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Remondelli, Raphael E., 216 Littleton av., Newark
Renzulli, Francesco, 228 S. Seventh st., Newark
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Restaino, Charles F., 465 Parker st., Newark
Rettig, Isidor L., 36 Milford av., Newark
Ribbans, Robert C., 63 Central av., Newark
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Richlin, Padie, 118 Johnson av., Newark
Ricketts, Henry E., 25 Shepard av., Newark
Riffin, Irving M., 419 Park st., Upper Montclair
Riggs, Vincent J., 295 N. Arlington av., East Orange
Rinzler, Elliot, 211 Roseville av., Newark
Ritota, Michael C., 85 Stuyvesant av., Newark
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 108 Glen av., Maplewood
Roberts, Allison H., 26 S. Ninth st., Newark
Roberts, Charles, 109 South Munn av., E. Orange
Roberts, David C., 3 Glen Oaks av., Summit
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 500 Belgrove dr., Arlington
Robie, Theodore R., 144 Harrison st., East Orange
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Romano, Patrick J., 310 Central av., Orange
Rommer, J. Jay, 25 Ingraham pl., Newark
Rose, Salvatore J., 242 Ivy court, Orange
Roseman, Herman I., 581 Ridgewood av., Glen Ridge
Rosen, Charles D., 115 S. Munn av., East Orange
Rosen, Emanuel, 692 High st., Newark
Rosen, Frank L., 32 Johnson av., Newark
Rosenbaum, Samuel X., 261 Main st., West Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenberg, Lillian M., 334 Bloomfield av., Montclair
Rosenthal, Arnold J., 41 Renner av., Newark
Rosenthal, Oscar J., 54 Van Ness pl., Newark
Rosenthal, Sydney, 202 Clinton av., Newark
Ross, Ira S., 190 Clinton av., Newark
Rost, Adolf S., 461 Mountainview av., Orange
Roston, Mark A., 63 Hansbury av., Newark
Roth, Ferdinand L., 98 S. Munn av., East Orange
Rothgesser, Jerome C., 14 Leslie st., Newark
Rothhouse, Burnet, 31 Lincoln Park, Newark
Rothschild, Daniel L., 31 Lincoln Park, Newark
Rotondi, Leonard J., Army
Rozsa, Stephen, 837 S. 11th st., Newark
Rubin, Abraham A., 240 Holmes st., Belleville
Rubin, Sidney, 170 Hawthorne av., Newark
Ruccia, Arthur, 107 Clifton av., Newark
Rudomanski, Victor, 103 Duke st., Kearny
Ruggio, Joseph, 8 Hedden ter., North Arlington
Rumage, William T., 513 Sanford av., Newark
Runyan, William J., 106 Broad st., Bloomfield
Russomanno, Paul, 497 Mt. Prospect av., Newark
Russomanno, Raymond L., 227 Clifton av., Newark
Sager, Bernard, 176 Millburn av., Millburn
Salmon, George G., Jr., 243 S. Harrison st., E. Orange
Salsberg, Ralph H., 23 Johnson av., Newark
Samson, Norman D., 543 Kearny av., Kearny
Sandford, Francis R., 30 Academy rd., Caldwell
Santangelo, Joseph A., 218 Grafton av., Newark
Santora, Philip J., 361 Roseville av., Newark
Santoro, Thomas A., 141 Sanford st., East Orange
Saporito, Archibald R., 119 Ridge rd., N. Arlington
Saracino, Frank J., 107 Grand pl., Arlington
Sarno, Anthony, 130 Parker st., Newark
Sarno, John, 130 Parker st., Newark
Saslow, Benjamin I., 102 Shanley av., Newark
Saslow, Stella K., 102 Shanley av., Newark
Sasso, Albert, 533 Mt. Prospect av., Newark
Savage, Eric D., 120 Prospect st., South Orange
Savel, Lewis E., 73 Shanley av., Newark
Sax, Max T., Army
Sbarra, Francesco C. N., 189 Roseville av., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaaf, Royal S., 51 Ellery st., Cambridge, Mass.
Schaefer, Kenneth F., 763 Broad st., Newark
Schaffer, Barney, 10 Van Reyper pl., Belleville
Schaffer, Nathan, 172 S. Arlington av., East Orange
Schectman, Vera, 97 Lyons av., Newark
Scheiber, Geza, 769 Kearny av., Arlington
Scheller, George A., 65 Old Short Hills rd., Sh't Hills
Scher, Maurice A., 137 Lyons av., Newark
Schiffmann, Samuel, 107 Spruce st., Newark
Schmukler, Jacob, 16 Johnson av., Newark
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Leo, 171 Ferry st., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schoenau, Carl W., 15 Highland av., Glen Ridge
Schotland, Clement E., 31 Lincoln Park, Newark
Schram, William S., 19ABrookdale Gard'ns,Bloomf'd
Schramm, Joseph A., 572 High st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schults, Anna R., 25 Abington av., Newark
Schurman, Francis H. C., 35 Smull av., Caldwell
Schwartz, Harold, 200 Clinton av., Newark
Schwartz, Mortimer L., 636 Stuyvesant av.,Irvington
Scott, Harold R., 68 Central av., Orange
Scott, Norman M., 790 Broad st., Newark
Scranton, Charles W., 59 Washington st., E. Orange
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark
Seidman, Joshua I., Army
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 115 Connett pl., South Orange
Sena, Marie A., 561 S. Orange av., Newark
Sevringhaus, Elmer L., Rensselaer rd., Essex Fells
Seward, William H., 188 S. Essex av., Orange
Shaffrey, Thomas A., 658 Grove st., Irvington
Shaner, Ralph D., 94 Hillside av., Nutley
Shannon, James B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montclair
Shapiro, Irving, 31 Lincoln Park, Newark
Shapiro, Louis, 146 Broad st., Newark
Shapiro, Ralph N., 668 Clinton av., Newark
Shapiro, Samuel A., 209 Avon av., Newark
Shapiro, Sydney H., 334 Union av., Irvington
Shaul, Frederick G., 10 Washington st., Bloomfield
Shaul, John F., Navy
Shaw, John J., 31 Lincoln Park, Newark
Sheehan, Daniel C., 535 Sanford av., Newark
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Arthur E., 70 Woodland rd., Maplewood
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 31 Lincoln Park, Newark
Shlionsky, Herman, 47 South Park st., Montclair
Shor, David M., 32 S. Munn av., East Orange
Shreehan, Hubert F., 615 Summer av., Newark
Shulman, Murray W., 913 S. 20th st., Newark
Siegel, Jack G., 32 Johnson av., Newark
Siegel, Jacob W., 96 S. Tenth st., Newark
Siegel, Leo, 234 Roseville av., Newark
Siegel, Robert, 96 S. Tenth st., Newark
Silberner, Herbert B., 99 Hillside av., Newark
Silver, Albert M., 89 Lincoln Park, Newark
Silverman, S. Andrew, 860 S. 11th st., Newark
Silverstein, Benjamin J., 32 Hillside av., Newark
Silverstein, Jacob M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, George F., 541 Page av., Lyndhurst
Simon, Franklin, 89 Lincoln Park, Newark

Simon, Henry, 5 Vermont av., Newark
Simon, Ludwig L., 29 Hillside av., Newark
Singer, Max, 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., East Orange
Sivolella, Nicholas W., 245 Clifton av., Newark
Siwek, Stanley, 428 Central av., Harrison
Skwirsky, Joseph, 37 Randolph pl., Newark
Slavin, Paul, 31 Lincoln Park, Newark
Smalley, Sara D., 530 Clifton av., Newark
Smalzried, Elmer W., 69 Woodland av., E. Orange
Smarzo, Marjorie M., Univ. of Ill., Champaign, Ill.
Smith, Alan L., 32 Washington st., East Orange
Smith, Charles H., 264 Ridgewood av., Glen Ridge
Smith, Christopher A., 43 Glen Ridge Pkw., Glen R.
Smith, Ellis L., Essex County Iso. Hosp., Belleville
Smith, Harold W., 179 Lincoln av., Orange
Smith, Henry G., Essex County Hosp., Cedar Grove
Smith, J. Meredith, 198 Valley rd., Montclair
Smith, Leonard H., 32 Washington st., East Orange
Smith, Thayer A., Forest dr., Short Hills
Sobin, Julius, 190 Clinton av., Newark
Sobol, Herman, 205 Roseville av., Newark
Sofman, Archie, 27 Nye av., Newark
Solk, Arthur G., 47 Lincoln Park, Newark
Solomon, Harold, 79 Shanley av., Newark
Somberg, Harold, 31 Lincoln Park, Newark
Somers, Fred L., 144 Harrison st., East Orange
Soschin, Samuel J., 31 Lincoln Park, Newark
Spallone, Joseph C., 123 Mt. Prospect av., Newark
Sparks, Spurgeon, Jr., 21 Oakwood av., Orange
Sperling, Irving L., 32 Johnson av., Newark
Sperling, Walter, 29 Oxford st., Montclair
Spinner, Samuel L., 15 Third st., Elizabeth
Spinosa, William J., 201 Littleton av., Newark
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 366 S. Orange av., S. Orange
Stahl, Alfred, 160 Lincoln av., Newark
Stahl, Charles, 659 Sanford av., Newark
Staknevich, John H., 309 Myrtle av., Irvington
Stanley, Thomas A., 77 Beech st., East Orange
Statman, Arthur J., 17 Leslie st., Newark
Statman, Bernhardt, 849 S. 12th st., Newark
Stearns, Thornton, 312 S. Harrison st., East Orange
Steiner, Edwin, 31 Lincoln Park, Newark
Steiner, Herbert, 350 Stuyvesant av., Irvington
Stern, David A., 127 Lyons av., Newark
Stern, Max E., 2 Milford av., Newark
Stern, Morton M., 24 Girard pl., Newark
Stevens, Donald J., 1479 Compton ter., Hillside
Stevens, Merton H., 58 S. Maple av., East Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stiles, C. Campbell, 713 Park av., East Orange
Stoddard, Gordon V., 96 Glenwood av., E. Orange
Stokes, Donald E., 120 Prospect st., South Orange
Stoll, George F., 330 Washington av., Belleville
Stoner, William H., 2 Broad st., Bloomfield
Strack, Vincent J., 1072 S. Orange av., Newark
Strassburger, Paul J., Jr., 330 Wash'gt'n av.,Bellev'le
Straub, Herbert H., 242 Springdale av., East Orange
Straus, Max, 87 Harrison pl., Irvington
Strauss, Frederick, 845 S. 12th st., Newark
Strauss, Max, 190 Clinton av., Newark
Strauss, William T., Jr., 8 Chester rd., Up. Montclair
Strazza, John A., 183 Broad st., Bloomfield
Streen, Morris E., 908 Bergen st., Newark
Sturchio, Eugenio, 178 Mt. Prospect av., Newark
Suesserman, Henry, 389 Lyons av., Newark
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove
Svenson, Sven E.,Newark-Pompton Tpke.,P'pt'nPl'ns
Swain, Richard D., Jr., 211 Roseville av., Newark
Sweeley, William J., 17 Smull av., Caldwell
Symes, Earl R., 544 Belgrove drive, Kearny
Szelewa, Edward S., 87 Stuyvesant av., Newark
Szivos, Louis A., 160 Glenwood av., East Orange
Taff, Harry, 165 Roseville av., Newark
Taffet, Seymour, 55 W. Passaic av., Bloomfield
Taffet, William, 379 Union av., Belleville
Tansey, W. Austin, Jr., 169 Hobart av., Short Hills
Tarbell, Harold A., 13 Pennington st., Newark
Taterka, Adrian, 3 Gates av., Roseland
Tenney, Albert S., 6 N. Munn av., East Orange
Thomas, John H., 270 Lenox av., South Orange
Thomison, Harry E., 605 Broad st., Newark
Thompson, Frank F., Jr., 261 Orange rd., Montclair
Thompson, Kenneth W., Organon, Inc., Orange
Thornhill, Arthur C., 47 Forest st., Montclair
Thornley, William F., 495 Prospect st., Maplewood
Thum, Kurt W., 366 Main st., West Orange
Tillis, Herman H., 31 Lincoln Park, Newark
Tilton, William R., 763 Broad st., Newark
Tobey, Franklin J., 11 Hazelwood av., Newark
Tobey, John R., 11 Hazelwood av., Newark
Tocci, Frank, 74 Grove st., Montclair
Toczek, Heinrich A., 391 Bergen st., Newark
Tomec, Richard F., 70 Harrison av., Montclair
Torppey, John J., 472 Sanford av., Newark
Trautwein, Charles F., 131 Nesbit ter., Irvington
Travers, Frank A., 485 Park av., Orange
Troedsson, Bror S., 188 S. Essex av., Orange
Tucker, Albert B., 47 Lincoln park, Newark
Tuly, Ralph, 134 S. Kingman rd., South Orange
Tunis, Benno B., 22 Ingraham pl., Newark
Turi, Amedeo E., 407 Mt. Prospect av., Newark
Turner, Charles F., 151 Grove st., Montclair
Tushnet, Leonard, 662 18th av., Irvington
Tutela, Arthur C., 220 S. Seventh st., Newark
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 92 Fleming av., Newark
Ulvestad, Lawrence E., 119 Irvington av., S. Orange
Underwood, Robert, 345 Washington av., Belleville
Urbach, George, 181 Chancellor av., Newark
Valentin, Irmgard, 131 S. Harrison st., East Orange
Vallario, Frank A., 333 Clifton av., Newark
Van Amberg, Robert J., 25 Trinity pl., Montclair
Vander Veer, H. Garrett, 295 M'tgomery st., Bl'mf'd
Van Emburgh, George H., 575 Belgrove dr.,Arlingt'n
Van Gieson, Edward J., 71 Watsessing av., Bloomf'ld
Vannatta, George W., 226 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Van Ness, Walter J., 41 Park pl., Bloomfield
Villanova, Ralph N., 266 S. Eighth st., Newark
Vincent, Nicholas F., 144 Harrison st., E. Orange
Virgilio, Anthony A., 87 S. Centre st., Orange
VonHofe, Frederick H., 572 Park av., East Orange
Wakeley, William E., 144 Harrison st., East Orange
Wakeley, William E., Jr., 47 Virginia av., Livingston
Waldron, Robert E., 699 Kearny av., Arlington
Walkenberg, Michael, 56 Clinton pl., Newark
Wallack, Charles A., 23 Treacy av., Newark
Walsh, Charles R., 95 W. Northfield av., Livingston
Walton, Ralph W., 102 Gates av., Montclair
Wannemacher, Paul, 87 Valley Way, West Orange
Ward, Chauncey P., 118 S. Grove st., East Orange
Ward, Elisabeth B., 555 William st., East Orange
Ward, William R., 112 Chancellor av., Newark
Ward, William R., Jr., 112 Chancellor av., Newark
Warnecke, Rudolph E., 43 S. Maple av., E. Orange
Warner, William H. A., 444 Central av., EastOrange
Warter, John P., Jr., 570 Belgrove dr., Arlington
Washington, William H., 321 High st., Newark
Waterman, Samuel M., 41 Shanley av., Newark
Weber, Francis C., 286 Mt. Prospect av., Newark
Weinberg, C. Richard, 597 Clinton av., Newark
Weiner, Harry, 283 Franklin st., Bloomfield
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 840 S. 11th st., Newark
Weinstein, Morris W., 942 Sanford av., Irvington

Weisbrod, Ferdinand G., 61 S. Munn av., E. Orange
Weiss, Fred, 129 Elizabeth av., Newark
Weiss, Louis, 519 Springfield av., Newark
Weiss, Selma, 190 Clinton av., Newark
Weiss, William I., 80 Clinton av., Newark
Welkind, Allen A., 32 Johnson av., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wesson, Harrison R., 198 Valley rd., Montclair
Weston, Clifford G., 27 Woodland av., Glen Ridge
Wheaton, Henry H., 42 Grove st., Verona
Wheeler, William K., 140 Roseville av., Newark
Whelan, Edward P., 460 Franklin av., Nutley
Whigham, Herbert H., Jr., 38 Madison av., Montclair
White, Robert R., 144 Harrison st., East Orange
Whitney, Leon H., 540 Broad st., Newark
Wiener, David, 196 Weequahic av., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 153 Roseville av., Newark
Williams, John J., 78 Walnut st., Newark
Willner, Albert, Army
Willner, Irving, 18 Waverly av., Newark
Willner, Milton, 822 S. 12th st., Newark
Willner, Philip, 852 S. 11th st., Newark
Willson, James H., 144 Harrison st., East Orange
Wilson, John H., Jr., 85 Halsted st., East Orange
Winfield, Irwin, 493 Central av., Newark
Winslow, John, 210 Orange rd., Montclair
Winter, Egon W., 825 S. Tenth st., Newark
Wolf, Raymond E., 251 Ridgewood av., Glen Ridge
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 225 Ballantine Parkway, Newark
Work, John L.. Mountainside Hosp., Montclair
Wortman, Harry C., Jr., 17 Warren st., Nutley
Wortman, Herbert M., 438 Park st., Up. Montclair
Wright, Robert E., 172 Concord dr., River Edge
Wright, Walter A., 2 Broad st., Bloomfield
Wuerthele, Virginia E., 560 Mt. Prospect av.,Newark
Wujciak, Henry J., 193 Warwick st., Newark
Wurts, Margaret M., 27 Wellesley av., Up. Montclair
Wurzel, Milton, 2 Farley av., Newark
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Wylly, Martin D., 320 Park av., Orange
Wynder, Alfred, 654 Lyons av., Irvington
Yablonsky, Max, 30 Shanley av., Newark
Yadkowsky, Emanuel, 637 High st., Newark
Yaguda, Asher, 61 Lincoln Park, Newark
Yates, Glen L., 67 Union st., Montclair
Yelin, Gabriel, 202 Clinton av., Newark
York, Jack S., 63 Baldwin av., Newark
Young, I. Henry, 220 Columbia av., Irvington
Zacher, Andrew A., 685 High st., Newark
Zager, Saul, 40 Spruce st., Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, Louis, 622 Varsity rd., South Orange
Zimmerman, Coler, 6 Colony dr., S., West Orange
Zingali, John A., 103 Glenridge av., Montclair
Zucker, Isadore, 112 Shanley av., Newark
Zukerberg, Nathan, 21 Johnson av., Newark
Zvaifler, Nathan, 46 Wilbur av., Newark
Zweibel, Leonard, 871 S. 11th st., Newark
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

ASSOCIATE MEMBERS

Areson, Robert H., 153 Bellevue av., Up. Montclair
Bonelli, William R., 30 Brookwood st., E. Orange
Calabrese, Angelo, 210 Littleton av., Newark
Chase, William M., 84 Astor st., Newark
Dooley, James H., 295 Montgomery st., Bloomfield
Farley, William, 17 Elwood pl., Newark
Garben, Louis F., Jr., 1182 Broad st., Bloomfield
Goodman Roland D., II, 265 S. Harrison st.,E.Orange
Halsted, Harry C., 77 Hawthorne av., Nutley
Howe, Edward G., 763 Broad st., Newark
Ibranyi, Gustav L., 413 Roseville av., Newark
Kenney, Howard W., 653 High st., Newark
Kessler, Morris, 626 Schuyler av., Arlington
Mann, Hillard, 431 Washington av., Belleville
Marchigiano, Anthony T., 310 Roseville av., Newark
Masterson, John E., 99 Brookdale Gardens, Bloomf'd
Mendelson, Max, 72A Brookdale Garden, Bloomfield
Miningham, William D., Jr., 18 Hedden ter., Newark
Peyser, Joseph, 100 Hollywood av., Hillside
Piserchia, Gerald J., 379 Washington av., Belleville
Sabety, Adrian M., 29 Park ct., Verona
Shapiro, Myron J., 89 Lincoln Park, Newark
Small, Leon I., 250 Millburn av., Millburn
Solomon, Philip, 32 Johnson av., Newark
Sorrentino, Louis V., 92 S. Oraton Parkw'y,E.Orange
Spieler, Ernesta M., 493 Central av., Newark
Sturman, William A., 219 S. Harrison st., E. Orange
Sullivan, John E., Jr., 839 Kearny av., Arlington
Teaze, Allison D., 62 Claremont av., Bloomfield
Thompson, John J., Mountainside Hosp., Montclair
Tucci, Peter, 74 Chestnut st., Montclair
Vail, William D., 73 Hobart av., Short Hills
Walker, John C., Jr., 15 Washington st., Newark
Wortzel, Martin H., 592 S. 19th st., Newark
Zutz, Harry, 10 Clinton pl., Newark

EMERITUS MEMBERS

Areson, William H., Ontario, Canada
Baird, Thompson M., Point Pleasant
Bleick, Theodore E., Newark
Carman, Fletcher F., Montclair
Chamberlain, Aims R., Maplewood
Dias, Joseph L., Lake City, Fla.
Emerson, Linn, Orange
Foster, Herbert W., Montclair
Halsey, Levi W., Montclair
Lowy, Otto, West Orange
Mabey, J. Corwin, Montclair
McCullough, Walter A., Daytona Beach, Fla.
Mierau, Ernest W., West Point Pleasant
Preston, Perry B., Newark
Price, Nathaniel G., Sarasota, Fla.
Ranson, Briscoe B., Jr., East Orange
Richardson, Arthur H., Montclair
Schachter, Harry A. H., Deal
Smith, Byron J., East Orange
Smith, Joseph J., Newark
Snavely, Earl H., Miami, Fla.
Szerlip, Leopold, Newark
Teeter, Charles E., Newark
Ward, Gertrude P., Bloomfield

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

ACTIVE MEMBERS

Battaglia, Albert J., 62 Hunter st., Woodbury
Beall, William T., Salem Pike, Clarksboro
Black, Maskell B., 128 E. High st., Glassboro
Bowersox, Clarence A., 509 N. Broad st., Woodbury
Brewer, David R., Jr., 112 N. Broad st., Woodbury
Brower, Francis M., III, 37 E. Center st., Woodbury
Burkett, J. Paul, 215 Delaware st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, A. Guy, 401 Broadway, Westville
Campo, Salvatore T., 200 Broadway, Westville
Chalfant, William P., Br'dway & Crafton av.,Pitman
Chesley, Norman K., 211 E. Main st., Maple Shade
Collins, Louis K., 54 State st., Glassboro
DiMarino, Anthony J., 735 Delaware st., Paulsboro
Faux, Frederick J., 32 N. Columbia st., Woodbury
Hingston, William L., 110 Main st., Williamstown
Hollinshed, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 16 N. Broad st., Woodbury
Hutcheson, Robert B., 215 Delaware st., Woodbury
Kehler, James G., Jr., Underwood Hosp., Woodbury
Laurusonis, John, 319 W. Broad st., Gibbstown
Lintz, Sidney Z., 525 Kings Highway, Swedesboro
Livengood, Baxter A., 64 Cooper st., Woodbury
Moore, Ralph L., 127 N. Broad st., Woodbury
Nelson, Harry, 36 Lupton av., Woodbury
Patterson, Isaac N., 26 Station av., Westville
Pedrick, William W., 11 West st., Glassboro
Pegau, Paul M., 31 Newton av., Woodbury
Puff, Robert C., 509 N. Broad st., Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sirotta, E. Bernard, 220 W. Broad st., Paulsboro
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., Woodbury
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Whitaker, Henry J., 10 S. Broadway, Pitman
Wilcox, John M., III, 415 Lake av., Pitman
Wright, Herman W., 818 S. Broadway, Pitman
Zahn, Jack R., 90 Paterson av., Gibbstown

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

ACTIVE MEMBERS

Abers, Bernard D., 565 Summit av., Jersey City
Africano, Julius V., 43 Columbia ter., Weehawken
Africano, Scipio H., 526 15th st., Union City
Agolia, Michael W., 2201 Palisade av., Union City
Albini, Mario, 204 Fifth st., Hoboken
Alpert, Edward, 661 Jersey av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Angelo, Joseph A., Bank Bldg., Secaucus
Annitto, John E., 170 Belmont av., Jersey City
Anrig, Grace E., 613 Summit av., Union City
Arbeit, Sidney R., 56 Gifford av., Jersey City
Aria, Charles J., 1818 Boulevard, Jersey City
Aria, Michael H., 31 Glenwood av., Jersey City
Aronoff, Herman L., 225 Claremont av., Jersey City
Aronowitz, Harry T., 923 Avenue C, Bayonne
Artaserse, George V., 185 Bergen av., Jersey City
Ash, Arthur F., 710 Boulevard, E., Weehawken
Auriemma, Michele, 421 Adams st., Hoboken
Aymar, Dorothy, 608 Fourth st., Union City
Bahnson, Conrad M., 170 Bowers st., Jersey City
Baldini, Charles F., Jr., 513 15th st., Union City
Baldini, Howard E., 513 15th st., Union City
Balsamo, Anthony J., 16 Enos pl., Jersey City
Barbarito, William N., 135 Bentley av., Jersey City
Bedrick, John J., 945 Avenue C, Bayonne
Behrens, Herman H. E., 312 Webster av., Jer. City
Benjamin, Harold C., 59 Crescent av., Jersey City
Bergen, Marshall, 100 Bentley av., Jersey City
Bergmeyer, Josef T., 6500 Palisade av., W. N. Y.
Berlin, Joseph I., 2600 Boulevard, Jersey City
Bieber, Harold B., 115 Fairview av., Jersey City
Bigliani, Urban R., 7308 Boulevard, North Bergen
Blakey, Abram P., 144 Wegman Pkwy., Jersey City
Bogacz, John, 3288 Boulevard, Jersey City
Boland, Lucy E., 27 Washington av., Arlington
Bookrajian, Edward N., 8027 Boulevard, N. Bergen
Borrone, Milton G., 2624 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 157 Wegman Pkwy., Jersey City
Boyers, Sidney S., 413 60th st., West New York
Boylan, Matthew E., 66 Van Reypen av., Jersey City
Boyle, Francis L., 805 Boulevard, Bayonne
Bradasch, George A., 1415 Central av., Union City
Brady, Thomas S., 678 Avenue C, Bayonne
Brauer, Charles, 2219 Boulevard, Jersey City
Brauer, Selig L., 2012 Boulevard, Jersey City
Braunstein, Sigmund C., 424 57th st., W. New York
Braunstein, William P., 1 Bellevue st., Weehawken
Bresev, Morris, 42 Broadman Parkway, Jersey City
Brewer, Catherine H., 808 Ocean av., Jersey City
Brick, George J., 43 Cottage st., Jersey City
Brozdowski, John J., 562½ Jersey av., Jersey City
Buckley, Richard F., 1122 Garden st., Hoboken
Butler, Vincent P., 33 Bentley av., Jersey City
Campana, Vincent R., 386 Fairmount av., Jersey City
Cannon, Edward A., 7512 Boulevard, North Bergen
Caridi, Salvatore, 431 59th st., West New York
Carpenter, Marcus E., 99 Storms av., Jersey City
Carr, Mary B., 1 Astor pl., Jersey City
Casciano, Adolph D., 189 Harrison av., Jersey City

Catlaw, J. Kenneth, 321 Stegman Pkw., Jersey City
Cebula, Jerome M., 7332 Boulevard, North Bergen
Cerchio, Michael, 132 Wayne st., Jersey City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chapman, Walter I., 700 Avenue C, Bayonne
Chayes, Sydney, 980 Avenue C, Bayonne
Chieffo, Henry, 1722 Boulevard, Union City
Chizik, John J., 162 W. 31st st., Bayonne
Christian, Henry A., 263 Woodlawn av., Jersey City
Cieri, Daniel S., 1515 Central av., Union City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 108 13th st., Hoboken
Cohen, Samuel, 100 Clifton pl., Jersey City
Cohen, Samuel A., 980 Summit av., Jersey City
Colonna, Joseph A., 5016 Hudson av.,West New York
Connell, Emmet J., 2227 Boulevard, Jersey City
Connell, John N., 26 Carlton av., Jersey City
Conti, Michael, 280 Fourth st., Jersey City
Conty, Anthony J., 318 48th st., Union City
Corless, Joseph F., 7 77th st., North Bergen
Cosgrove, Robert A., 186 Belmont av., Jersey City
Cosgrove, Samuel A., 88 Clifton pl., Jersey City
Costa, George J., 567 Jersey av., Jersey City
Cracco, Frederick A., 211 Palisade av., Union City
Cricco, Carl F., 909 Washington st., Hoboken
Cziraky, Anton, 516 34th st., Union City
D'Acierno, Pellegrino A., 1708 Palisade av., UnionC'y
Daly, Edmund J., 921 Bergen av., Jersey City
Danielson, John J., 4703 Tonnele av., No. Bergen
DeFuccio, Charles P., 12 Duncan av., Jersey City
De Fusco, G. Thomas, 330 Newark av., Jersey City
Deitmaring, Francis A., 7922 Boulevard, No. Bergen
Del Baglivo, Mario, 266 Newark av., Jersey City
DeMarco, Silverino V., 2780 Boulevard, Jersey City
DePietro, Vincent P., 520 48th st., Union City
Dershewitz, Irving, 835 Montgomery st., Jer. City
Detrano, Salvatore J., 903 Washington st., Hoboken
DeVincenzo, F. Richard, 629 Wash'gton st.,Hobok'n
Dolganos, Moses, 268 Palisade av., Jersey City
Donnelly, Joseph P., 58 Kensington av., Jersey City
Donohoe, Lucius F., 140 W. Eighth st., Bayonne
Doran, Ralph J., 200 11th st., Hoboken
Dougherty, Daniel D., 1218 Bloomfield st., Hoboken
Doyle, John J., 426 Fairmount av., Jersey City
Driscoll, Raymond S., 117 W. Fifth st., Bayonne
Dukes, Howard R., 220 Kearny av., Kearny
Edelstein, Isidore, 938 Hudson st., Hoboken
Elwood, Benjamin J., 91 W. 38th st., Bayonne
Ettinger, Samuel, 501 32nd st., Union City
Evans, J. Lawrence, 7117 Park av., Woodcliff
Faber, Edward, 154 Bergen av., Jersey City
Fabriele, John B., 977 Avenue C, Bayonne
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Fattel, Henry C., 8300 Boulevard, North Bergen
Federer, John J., 69 Columbia ter., Weehawken
Feldman, Morris, 51 Bentley av., Jersey City
Felitti, Vincent J., 435 79th st., North Bergen
Feller, William, 283 Bergen av., Jersey City
Fenimore, Edward D., 77 Grace st., Jersey City
Fiaik, Harry, 337 52nd st., West New York
Ficke, Sylvia A., 906 Summit av., Jersey City
Fifer, William T., 746 Avenue C, Bayonne
Finger, Frederick A., 943 Avenue C, Bayonne
Finke, Charles H., 317 York st., Jersey City
Finke, Charles H., Jr., 317 York st., Jersey City
Finkelstein, Max, 3258 Boulevard, Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Fischer, Leo E., 70 Sherman pl., Jersey City
Flichtenfeld, Morris 283 Fourth st., Jersey City
Fliegel, Hilda C., 309 Baldwin av., Jersey City
Frank, Herman I., 98 W. 35th st., Bayonne
Frank, Morris, 920 Avenue C, Bayonne
Frank, Nathan, 180 Bowers st., Jersey City
Frankel, Henry, 229 60th st., West New York
Franklin, I. Harold, 191 Palisade av., Jersey City
Freyberger, George A., 85 Columbia ter.,Weehawken
Freymann, Walter, 5006 Hudson av., W. New York
Furman, Sol T., 344 Fairmount av., Jersey City
Garbarini, John G., 93 Clifton pl., Jersey City
Gerne, Timothy A., 972 Summit av., Jersey City
Ghee, Euclid P., 115 Claremont av., Jersey City
Giannasio, Joseph, 813 Montgomery st., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gitlitz, Abraham J., 54 Joyce rd., Tenafly
Goldman, David L., 42 W. 22nd st., Bayonne
Goldsmith, Alfred S., 8129 Boulevard, North Bergen
Gorenberg, Harold, 55 Bentley av., Jersey City
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1919 Boulevard, Jersey City
Greenberg, William B., 315 60th st., West New York
Greene, Albert D., 915 Palisade av., Union City
Greene, Harry, 90 Duncan av., Jersey City
Greene, Robert F., 1504 Central av., Union City
Grieco, Emil H., 19 W. 22nd st., Bayonne
Grossman, Harold W., 2553 Boulevard, Jersey City
Grossman, Morris, 921 Bergen av., Jersey City
Grossman, Rubin, 377 Avenue C, Bayonne
Grubowski, Joseph N., 477 Jersey av., Jersey City
Gurland, Benjamin B., 146 W. 37th st., Bayonne
Gurley, Katharine A., 2671 Boulevard, Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Handler, Harry, 305 York st., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard, E., Weeh'wk'n
Harz, William V., 880 Avenue C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jersey City
Hauptman, Harry, 88 Sherman pl., Jersey City
Heilbrunn, Julius, 2540 Boulevard, Jersey City
Hekimian, Jacob H., 2314 Palisade av., Weehawken
Hershey, Harry H., 921 Bergen av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Higgins, Thomas A., 2616 Boulevard, Jersey City
Hillel, Joseph, 425 77th st., North Bergen
Hirsch, Solomon, 2553 Boulevard, Jersey City
Hollywood, James L., 219 Danforth av., Jersey City
Horowitz, Alexander S., 4614 Boulevard, Union City
Horowitz, Leo, 3644 Boulevard, Jersey City
Hosay, John, 243A Second st., Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Huss, Louis, 1722 Boulevard, Union City
Imhoff, John G., 913 Summit av., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Irving, Henry C., 27 Warner av., Jersey City
Jacks, Oscar, 476 Mercer st., Jersey City
Jaffe, Benjamin, 566 Bergen av., Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaques, J. Eugenia, 74 Waverly st., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Johnson, Archie W., 169 Claremont av., Jersey City
Joseph, Benjamin M., 2771 Blvd., Jersey City
Judy, Kenneth H., 2741 Boulevard, Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Kainer, Herbert, 4411 Boulevard, North Bergen
Kanengiser, Clifford H., 26 Gifford av., Jersey City
Kaplan, Herman B., 324 44th st., Union City
Katz, Sidney, 8116 Boulevard, North Bergen
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kemp, Norval F., 87 Sherman pl., Jersey City
Kiely, Eugene M., 800 Hudson st., Hoboken
Kimmel, M. Leonard, 3342 Boulevard, Jersey City
Klein, Julius, 2105 Palisade av., Union City
Kleiner, Charlotte A., 330 Crescent av., Leonia
Kolb, John M., 1611 Boulevard, North Bergen
Kook, Sol, 54 Grand pl., Arlington
Kooperstein, Samuel I., 191 Palisade av., Jersey City
Kornfield, Norman B., 52 Livingston av., Arlington
Kraemer, Samuel H., 309 Baldwin av., Jersey City

Kraut, Arthur M., 681 Bergen av., Jersey City
Kuhlmann, Alvin E., 527 37th st., Union City
Kun, Bertram, 135 Belmont av., Jersey City
Kurtz, Geza R., 116 Fairview av., Jersey City
Lakiszak, Roman T., 162 Harrison av., Jersey City
Landshof, Charles A., 50 Glenwood av., Jersey City
Lane, Thomas F., 145 Garrison av., Jersey City
Lange, Louis C., 50 Clifton ter., Weehawken
Lawner, Ethel G., 25 Kensington av., Jersey City
Lawsing, G. Conde, 443 66th st., West New York
Lee, William A., 269 Jewett av., Jersey City
Leevy, Carroll M., 543 Bergen av., Jersey City
Lefkowitz, Jacob H., 445 64th st., West New York
Lempke, Richard J., 3 Armstrong av., Jersey City
Lepis, A. Albert, 39 Bentley av., Jersey City
Leuzzi, Darwin A., 2515 Palisade av., Union City
Levine, G. Irving, 100 Bentley av., Jersey City
Lewis, John F., Jr., 1201 Park av., Hoboken
Lieberson, Leonard, 20 62nd st., West New York
Lindroth, Lawrence V., 4525 Boulevard, N. Bergen
Lione, John G., 20 E. 32nd st., Bayonne
Lipshutz, Benjamin, 18 W. 22nd st., Bayonne
Lipshutz, Charles, 820 Avenue C, Bayonne
Little, Alonzo W., 120 Arlington av., Jersey City
Lobban, Robert B., 61 Gifford av., Jersey City
LoBuono, Joseph, 228 60th st., West New York
London, Randolph A., 7615 Park av., North Bergen
Londrigan, Joseph F., 832 Bloomfield st., Hoboken
Londrigan, Joseph F., II, 832 Bloomfield st.,Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Luczynski, Edward W., 726 Avenue C, Bayonne
Lupin, Edward E., 930 Boulevard, Bayonne
Lynch, James F., 1947 Boulevard, Jersey City
Lynch, Roland J., Mental Diseases Hosp., Secaucus
Lynn, Irving I., 2760 Boulevard, Jersey City
Macchia, Benjamin J., 358 Arlington av.,Jersey City
Mackin, John J., 596 Bergen av., Jersey City
Madaras, John S., 870 Avenue C, Bayonne
Madison, L. Keith, 358 Pacific av., Jersey City
Mahoney, Francis W., 41 Crescent av., Jersey City
Malinowski, John, 554½ Jersey av., Jersey City
Mandell, Sidney N., 313 Monastery pl., Union City
Manette, Milton, 535 41st st., Union City
Mangone, Edith, 174 Clinton av., Jersey City
Manno, Peter D., 843 Boulevard, Bayonne
Mansfield, Richard, 435 59th st., West New York
Marcus, Kurt, 85 Bowers st., Jersey City
Margolin, Samuel J., 1012 80th st., North Bergen
Markowitz, Benjamin B., 2749 Boulevard, Jer. City
Markowitz, Irwin B., 88 Gifford av., Jersey City
Marshall, Frank A., 2202 Palisade av., Weehawken
Mastromonaco, Joseph D., 790 Avenue C, Bayonne
Mathews, William J., 938 Hudson st., Hoboken
Matturri, Dominick A., 81 Gifford av., Jersey City
Maturi, Vincenzo E., 814 Boulevard, Bayonne
Mauriello, Dominic, 2630 Boulevard, Jersey City
Maver, William W., N. J. Trust Bldg., Jersey City
McCaffrey, Wallace T., 82 Highwood ter.,Weehawken
McCarron, James A., 727 Avenue C, Bayonne
McCarthy, John J., 1001 79th st., North Bergen
McGovern, Patrick J., 3284 Boulevard, Jersey City
McKeever, William J., 990 Summit av., Jersey City
McLean, Hugh A., 414 61st st., West New York
McLoughlin, John W., 34 W. 32nd st., Bayonne
Meehan, George E., 117 Mercer st., Jersey City
Meltzer, Louis, 837 Avenue C., Bayonne
Meyerson, Noah, 428 59th st., West New York
Mickewich, Stephen A., 817 Avenue C, Bayonne
Milanesi, Armand M., 614 79th st., North Bergen
Modarelli, Walter H., 1505 Central av., Union City
Monica, Louis A., 875 Boulevard, Bayonne
Moriarty, John F., 723 Washington st., Hoboken
Morley, Grace C., 1218 Hudson st., Hoboken
Morris, David G., 11 W. 26th st., Bayonne
Muccia, John J., 7 Tonnele av., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Boulevard, Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 1814 West st., Union City
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 2521 Boulevard, Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nafash, Shafeek, 1117 16th st., North Bergen
Norton, James F., 58 Kensington av., Jersey City
O'Brien, John R., 174 Bowers st., Jersey City
Ockene, Abraham, 2415 Palisade av., Union City
O'Connell, William, 87 Clifton ter., Weehawken
O'Connor, John J., 2124 New York av., Union City
Oesterreicher, Desider, 427 Bergen av., Jersey City
Offenkrantz, William C., 121 Vroom st., Jersey City
Ortolano, James J., 911 Washington st., Hoboken
O'Sullivan, John R., 11 Quincy av., Arlington
Pacicco, Michele, 609 Pavonia av., Jersey City
Padney, Edward V., 452 Jersey av., Jersey City
Pagliughi, John J., 1915 Palisade av., Union City
Pearlstein, Frank, 325 60th st., West New York
Peckman, Abram, 2511 Boulevard, Jersey City
Penchansky, Samuel, 719 Avenue C, Bayonne
Penchansky, Samuel J., 847 Avenue C, Bayonne
Perkel, Harold, 441 Boulevard, Bayonne
Perkel, Louis L., 135 Jewett av., Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Perrone, Arthur F., 415 60th st., West New York
Piltz, George F., 153 69th st., Guttenberg
Plavin, Nathan J., 8010 Boulevard, North Bergen
Pontery, Herbert B., 89 Bowers st., Jersey City
Potter, Benjamin P., 821 Bergen av., Jersey City
Price, H. Preston, 317 Hamilton rd., Ridgewood
Prince, Samuel, 7702 Park av., North Bergen
Purdy, Charles H., 35 Highland av., Jersey City
Pusin, Max, 88 Van Reypen st., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Quigley, Frederic J., 100 Clifton pl., Jersey City
Quinn, John J., 921 Bergen av., Jersey City
Raccuia, Vincent, 431 59th st., West New York
Raso, Frank L., 1218 Central av., Union City
Reilly, Raymond, 8210 Fourth av., North Bergen
Resnick, Solomon, 932 Avenue C, Bayonne
Restivo, Carl C., Jr., 3 Webster av., Jersey City
Reznikoff, Leon, 10 Columbia ter., Weehawken
Rieman, Francis E., 3564 Boulevard, Jersey City
Riordan, John P., 40 Midland av., Arlington
Rosen, Charles E., 321 23rd st., Union City
Rosenberg, Albert B., 120 Crescent av., Plainfield
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rosenthal, Alfred E., 79 West 32nd st., Bayonne
Rossi, John R., 119 W. 36th st., Bayonne
Rothberg, Moses, 438 59th st., West New York
Rother, Carl, 20 48th st., Weehawken
Rubenstein, Eli, 783 Avenue C., Bayonne
Rubensteln, Robert, 2758 Boulevard, Jersey City
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., 2414 New York av., Union City
Russillo, Philip, 155 Clerk st., Jersey City
Rydwin, Chester, 137 Grand st., Jersey City
Sabini, Cecil F., 603 Jefferson st., Hoboken
Sacco, Anthony G., 2200 New York av., Union City
Sachs, Fred, 48 Warner av., Jersey City
Sachs, Wilbert, 921 Bergen av., Jersey City
Sager, Harold, 19 W. 22nd st., Bayonne
Sakowski, John P., 20 W. 22nd st., Bayonne
Saladino, Anthony J., 427 15th st., Union City
Salvatore, Francis P., 31 Glenwood av., Jersey City
Salzmann, Bertold, 89 Gifford av., Jersey City
Santangelo, Stephen, 461 Jersey av., Jersey City
Saradarian, Albert V., 921 Bergen av., Jersey City
Schapiro, Morris, 800 Avenue C, Bayonne
Schenker, Benjamin N., 246 Fifth st., Jersey City
Schenker, Israel N., 3697 Boulevard, Jersey City

Schept, Samuel S., 523 37th st., Union City
Schimenti, Matteo, 1883 Boulevard, Jersey City
Schlein, August, 707 Park av., Hoboken
Schneider, Harry M., 89 Gifford av., Jersey City
Schneider, Louis A., 412 61st st., West New York
Schorr, Herman E., 26 Lincoln Parkway, Bayonne
Schuchner, William F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schulman, Abraham S., 4518 Boulevard, Union City
Schwartz, Harold B., 3906 Bergenline av., Union City
Schwartz, Lewis, 2695 Boulevard, Jersey City
Schwarz, Berthold T. D., 2787 Boulevard, Jersey City
Schwarz, John, 83 Highwood ter., Weehawken
Scialli, Vincent A., 278 Fourth st., Jersey City
Sciarrillo, Louis F., 105 Newark st., Hoboken
Sciorsci, Edward F., 609 Bloomfield st., Hoboken
Sciorsci, Mario, 609 Bloomfield st., Hoboken
Scott, Samuel G., 141 Bergen av., Jersey City
Sheeran, Vincent J., 101 Bentley av., Jersey City
Sherman, Abraham, 68 Clifton ter., Weehawken
Shipman, Robert T., 907 Summit av., Jersey City
Siegel, Lester, 180 Belmont av., Jersey City
Silich, Robert L., 875 Boulevard, E., Weehawken
Silon, Milton R., 907 Washington st., Hoboken
Silvera, Salomon, N. J. Trust Bldg., Jersey City
Simeone, Peter A., 138 Clerk st., Jersey City
Simpson, David B., 9 East 35th st., Bayonne
Singer, Sina S., 3443 Boulevard, Jersey City
Sinnott, Gerald W., Medical Center, Jersey City
Smith, Meyer, 14 Webster av., Jersey City
Solomon, Louis, 7 Tonnele av., Jersey City
Spano, Frank, 320 47th st., Union City
Spath, William H., 722 Hudson st., Hoboken
Spohn, Eugene L., 16 Riverton dr., San Francisco, C.
Starr, Benjamin, 70 Sherman pl., Jersey City
Starr, Eli, 611 79th st., North Bergen
Statile, Pasquale A., 598 Pavonia av., Jersey City
Stefansin, Frank, 1601 Boulevard, North Bergen
Stein, Albert, 600 80th st., North Bergen
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 819 First st., Secaucus
Stuart, William C., 1 Newark st., Hoboken
Suermann, John F., 220 Palisade av., Weehawken
Sussman, Harold, 103 Tenth st., Hoboken
Swiney, Juliana C., 325 Avenue C, Bayonne
Swiney, Merrill A., III, 325 Avenue C, Bayonne
Talty, John C., 935 Washington st., Hoboken
Tannert, Carl H., 331 77th st., North Bergen
Tataryan, Hovsep, 2024 New York av., Union City
Terwedow, Walter G., 518 79th st., North Bergen
Tidwell, Harold F., 6101 Boulevard, E., W. New York
Trewhella, Arthur P., 376 Fairmount av., Jersey City
Troast, Leonard, 2801 Boulevard, Jersey City
Troum, Nathan, 82 Danforth av., Jersey City
Tsucalas, James C., 29 Highland av., Jersey City
Turkish, Martin, 1025 Avenue C, Bayonne
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 2415 New York av., Union City
Varriano, John L., 3263 Boulevard, Jersey City
Vespignani, Pasquale, 863 Montgomery st., Jer. City
Visceglia, Frank R., 430 74th st., North Bergen
Visconti, Joseph A., 105 Newark st., Hoboken
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Wager, Henry P., 39 Gifford av., Jersey City
Wallack, Eli A., 92 Fairview av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2784 Boulevard, Jersey City
Weber, Laura E., 305 23rd st., Union City
Weisman, Herbert, 273 Avenue A, Bayonne
Weiss, Morris J., 734 Avenue C, Bayonne
Weston, Elaine, 40 Midland av., Arlington
Wheeler, James A. V., 85 VanReypen st., JerseyCity
Wilcox, Frank A., 329 60th st., West New York
Yanowitz, Bernard, 165 Jewett av., Jersey City
Yeaton, William L., Jr., 204 11th st., Hoboken
Yontef, Reuben, 851 Avenue C, Bayonne
Yudkoff, William, 770 Avenue A, Bayonne
Zbar, Joseph E., 2690 Boulevard, Jersey City
Zitani, Alfred M., 937 Washington st., Hoboken
Zuckerberg, Irving, 800 Avenue C, Bayonne

EMERITUS MEMBERS

Atwell, David R., East Orange
Connell, John N., Jersey City
Gille, Hugo, Jersey City
Keegan, Thomas D., Deal
Older, Benjamin, St. Petersburg, Fla.
Rosecrans, James H., Hoboken
Selinger, Samuel, Lake Worth, Fla.
Sexsmith, George H., Los Angeles, Cal.
Stout, J. Phillip, Red Bank
Timlin, James W., Arlington
Woelfle, Henry E., East Orange

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

ACTIVE MEMBERS

Baker, Philip W., High Bridge
Bambara, Aurelius J., 6 North Main st., Flemington
Beatty, Hannah J., Clinton Farms, Clinton
Boyer, Charles G., Annandale
Christensen, Alexander H., Lebanon
Clark, Frank G., White House Station
Coleman, Austin H., 93 Center st., Clinton
Ctibor, Vladimir F., Califon
Davidson, Henry A., R. D. 2, Flemington
Ecker, Joseph L., Clinton
Felder, Samuel, 221 Main st., Flemington
Fluck, Paul H., 73 N. Union st., Lambertville
Fritz, John F., Jr., 95 Main st., Flemington
Fuhrmann, Barclay S., 10 Main st., Flemington
Fuhrmann, John B., 10 Main st., Flemington
Germain, Raymond J., 75 Center st., Clinton
Hamilton, Lloyd A., 46 York st., Lambertville
Harps, James A., 72 Center st., Clinton
Henry, George, 33 Mine st., Flemington
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Lane, Edgar W., 46 Main st., Bloomsbury
Leaver, Morris H., Quakertown
Looloian, Mehran W., White House Station
Merrill, Edwin D., Green st., Milford
Smith, Joseph A., N. J. Sanatorium, Glen Gardner
Tompkins, Grenelle B., 52 Broad st., Flemington

HONORARY MEMBERS

Quigley, Frederic J., Jersey City
Sommer, George N. J., Trenton

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 9:00 p. m., in the State Society Headquarters, Trenton. Annual Meeting in December. Annual Banquet in November.

ACTIVE MEMBERS

Abey, William J. H., 65 S. Main st., Pennington
Abrams, Henry, 195 Nassau st., Princeton
Ackley, David B., 21 N. Clinton av., Trenton
Albert, Perry, 2780 S. Broad st., Trenton
Apple, Stanley B., 1520 Brunswick av., Trenton
Applestein, Robert, 375 W. State st., Trenton
Aronis, Harry R., 935 W. State st., Trenton
Austin, Henry J., 96 Bellevue av., Trenton
Barlow, John D., 232 Stockton st., Hightstown
Barry, R. Grant, 908 W. State st., Trenton
Bayne, Joseph K., Army
Beairsto, Everett B., 224 W. State st., Trenton
Belford, Ralph J., 90 Nassau st., Prlnceton
Bellis, Horace D., 437 E. State st., Trenton
Bergsma, Daniel, State Health Dept., Trenton
Berman, Jacob J., 409 Market st., Trenton
Bernstein, Bertram, 329 Clearfield av., Trenton
Bird, Ivan F., 1213 Hamilton av., Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton
Bonnet, W. Laurence, 2791Not'gham way,Mercerv'le
Borrella, Dominic D., 476 Hamilton av., Trenton
Brenna, Joseph D., 448 Hamilton av., Trenton
Burbidge, J. Raymond, 163 Nassau st., Princeton
Burns, Joseph R., 254 S. Olden av., Trenton
Burroughs, Charles W., 688 Stuyvesant av., Trenton
Burroughs, Edmund W., 701 W. State st., Trenton
Byer, M. Yale, 442 Greenwood av., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 125 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton
Cella, Charles F., 359 Hamilton av., Trenton
Chandler, Swithin, Jr., 4273 S. Broad st., Yardville
Charleroy, Durant K., 935 Greenwood av., Trenton
Chesner, William A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Christian, Elizabeth I., Station A, Trenton
Clark, Alice L., 206 W. State st., Trenton
Clunan, Ambrose P., 851 Hamilton av., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohen, Herman, 1301 Hamilton av., Trenton
Cohen, William, 1007 Greenwood av., Trenton
Colavita, James J., 433 Princeton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Commini, Frank F., 439 Bellevue av., Trenton
Cone, Thomas E., Jr., 108 N. Stanworth dr.,Prlnceton
Corlo, George A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cottone, R. John, 683 Princeton av., Trenton
Cowlbeck, H. Donald, 224 W. State st., Trenton
Crane, Warren E., 974 S. Broad st., Trenton
Davenport, Irwin P., 545 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
de Blois, Joseph A., Jr., 1008 Hamilton av., Trenton
Deitz, Joseph R., 915 W. State st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Dimun, John T., 1000 S. Broad st., Trenton
Doranz, Harold K., 502 W. State st., Trenton
Drezner, Henry L., 216 W. State st., Trenton
Eames, William N., 1871 Pennington rd., Trenton
Eckstein, David, 407 Greenwood av., Trenton
Edwards, Walter R., 2624 Quaker Br. rd.,Mercerville
Elias, Elmer J., 474 Greenwood av., Trenton
Ellis, Ralph W., 64 Fairview av., Morrlsville, Pa.
Engelhart, Ferdinand K., 28 Oak Lane, Trenton
English, Harrison F., III, 160 W. State st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fedor, John A., 969 S. Broad st., Trenton
Fessler, A. James, 1544 S. Broad st., Trenton
Finegan, Paul J., 200 W. State st., Trenton
Finkle, Lester J., 495 W. State st., Trenton
Fiorello, Joseph R., 689 Princeton av., Trenton
Fluck, David A., 626 W. State st., Trenton
Forer, Robert, 434 Bellevue av., Trenton
Franklin, Charles M., 56 Elm rd., Princeton
Franzoni, Andrew E., 938 Brunswick av., Trenton
Freund, Seelig, 617 W. State st., Trenton
Friedman, Max, 849 W. State st., Trenton
Friedman, Meyer H., 949 W. State st., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Frosch, Frank J., 1423 Pennington rd., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Garber, Robert S., N. J. State Hospital, Trenton
Garwood, Norman W., Church st., Crosswicks
Gian-Grasso, Joseph A., 343 Hamilton av., Trenton
Gindhart, Floyd D., 1213 Hamilton av., Trenton
Gindhart, John H., 1213 Hamilton av., Trenton
Goldberg, Benjamin M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
Goyne, James B., 2663 Main st., Lawrenceville
Graham, Ernest E., 66 Clark av., Somerville
Greeley, David M., 245 Nassau st., Princeton
Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Hafetz, M. Morris, 114 Centre st., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Haney, John J., 850 Hamilton av., Trenton
Harman, J. Reginald, 824 W. State st., Trenton
Hiden, Joseph C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 375 W. State st., Trenton
Hofbauer, Ernest, 608 Parkway av., Trenton
Horhovitz, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingh'm way,HamiltonSq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., Yardville av., Hamilton Square
Irmisch, George W., 375 W. State st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 926 W. State st., Trenton
Kaplan, Harry, 186 W. State st., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempner, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
Knauer, Charles H., Jr., 214 W. State st., Trenton
Kohn, Joseph J., 143 E. State st., Trenton
Kondor, Joseph S., 1414 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Mathew R., 628 W. State st., Trenton
Larsson, Evert A., N. J. State Hospital, Trenton
Laufenberg, Joseph W., 1544 S. Broad st., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Ledden, Lewis J., 1104 Hamilton av., Trenton
Lettiere, Anthony J., 425 E. State st., Trenton
Levy, Irvin, 222 W. State st., Trenton
Lewis, Sydney B., 194 W. State st., Trenton
Little, William R., 493 W. State st., Trenton
Lloyd, Samuel J., 178 W. State st., Trenton
Lynch, Donald C., 885 Stuyvesant av., Trenton
MacDermid, Lynden E., 506 Farnsw'th av.,Bordent'n
Magson, Albert E., 302 S. Main st., Hightstown
Mains, M. Paul, Mercer Hospital, Trenton

Majeski, Henry J., 930 Brunswick av., Trenton
McCarthy, William P., 1203 Parkside av., Trenton
McConville, Edward B., 1213 Hamilton av., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Migliori, Angelo, 531 S. Clinton av., Trenton
Miller, Earle K., 2512 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Raymond E., 192 W. State st., Trenton
Miller, Samuel R., 407 S. Main st., Pennington
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 1329 Greenwood av., Trenton
Moore, J. Leonard, 59 Westcott rd., Princeton
Moore, William J., 10 N. Olden av., Trenton
Moriconi, Albert F., 438 Hamilton av., Trenton
Mountford, William E., 217 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 117 Buckingham av., Trenton
Nayfield, Ronald C., 990 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
Ogden, Andrew E., 1829 Greenwood av., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Paul, 72 N. Clinton av., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Philo, Seymour S., 849 Hamilton av., Trenton
Pierson, Carl L., 900 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Pinerman, Robert B., 539 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Podkul, Theodore, 1854 Brunswick av., Trenton
Pollard, William E., 245 Nassau st., Princeton
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 845 W. State st., Trenton
Poyas, Morton L., 730 W. State st., Trenton
Proctor, Francis E., 332 W. State st., Trenton
Prunetti, Carmen, 311 Chestnut av., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Purcell, Ernest F.,Jr.,2630 NottinghamWay,M'c'rv'le
Rachunis, Michael, Fifth & Riverside avs., Roebling
Ragany, Joseph, VA Hospital, Wilmington, Del.
Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 272 Nassau st., Princeton
Rathauser, Frank, 375 W. State st., Trenton
Rathmell, Thomas K., Mercer Hospital, Trenton
Reisinger, Paul B., 369 W. State st., Trenton
Resnick, Nathan, 205 Market st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Robinson, Aaron J., 1757 S. Broad st., Trenton
Rogers, Laurence H., Donnelly Mem. Hosp., Trenton
Rose, William G., 232 Stockton st., Hightstown
Rosso, John D., 194 Nassau st., Princeton
Rothman, Sidney, 870 Stuyvesant av., Trenton
Rowan, Henry M., 224 W. State st., Trenton
Sackin, Stanley, 834 W. State st., Trenton
Sacks-Wilner, Arthur, 225 W. State st., Trenton
Sacks-Wilner, Erwin P., 225 W. State st., Trenton
Salvatore, Joseph T., 324 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scasserra, Benedict B., 164 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Schnur, Bernard, 731 W. State st., Trenton
Seely, Roy B., 104 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Selecky, Medard A., 35 S. Main st., Allentown
Sharbaugh, George B., 212 W. State st., Trenton
Shear, M. Murray, 1158 E. State st., Trenton
Shepp, Murray, 192 W. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunsw'k av., Trenton
Slack, Clarence J., 230 W. State st., Trenton
Smith, B. Earl, 1017 Greenwood av., Trenton
Smith, DeWitt H., 245 Nassau st., Princeton
Smith, Frank W., 1238 S. Clinton av., Trenton
Snegireff, Leonid S., 540 Parkway av., Trenton
Sollami, William R., 2331 S. Broad st., Trenton
Sommer, George N. J., 120 W. State st., Trenton
Sommer, George N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., E. School lane, Yardley, Pa.
Stein, Louis A., 226 W. State st., Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Straus, Walter, 1239 Greenwood av., Trenton
Sullivan, James M., III, 202 Spring st., Trenton
Summers, Alfred D., 71 Palmer sq., Princeton
Sutnick, Theodore B., 25 Richey pl., Trenton
Swern, Nathan, 399 W. State st., Trenton
Tenney, Luman H., 177 Prospect av., Princeton
Thurm, Arthur S., 225 W. State st., Trenton
Tomec, Otto C., 756 Parkway av., Trenton
Topley, Howard E., Jr., 8 Oak lane, Trenton
Treiber, Benjamin A., 219 W. State st., Trenton
Turner, Rodney C., 609 Greenwood av., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vento, Sebastian J., 452 Hamilton av., Trenton
Vine, Blair, 1437 S. Broad st., Trenton
Vol-Tretter, Marta, 501 W. State st., Trenton
Waldron, Edward L., 910 Stuyvesant av., Trenton
Warter, Peter J., 717 W. State st., Trenton
Waters, Charles H., 928 W. State st., Trenton
Watov, Samuel E., 178 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 1100 S. Broad st., Trenton
Whitaker, Darrell W., 802 Pennington av., Trenton
Wikoff, John L., 799 Pennington av., Trenton
Williams, Harry D., 829 W. State st., Trenton
Wilson, Joseph G., 560 Rutherford av., Trenton
Witman, H. John, Jr., 526 N. Clinton av., Trenton
Wittenborn, William F. J., 1635 Brunsw'k av.,Tr'nt'n
Wolff, Herbert M., 942 W. State st., Trenton
Yazujian, Levon D., 562 E. State st., Trenton
York, Wilbur H., Box 110, Princeton
Zeltmacher, Kurt, 308 W. State st., Trenton
Zimskind, Joshua N., 210 W. State st., Trenton

ASSOCIATE MEMBERS

Babad, Frederick, Tilton General Hosp., Fort Dix
Bacsik, Edward J., 456 Home av., Trenton
Chandler Jennie S., 56 College rd., Princeton
Coleman, William H., 140 Roxboro rd., Trenton
Cortelyou, Thomas P., 83 E. Prospect st., Hopewell
Cytowic, Edmund R., 883 Brunswick av., Trenton
Fares, Louis G., 471 Centre st., Trenton
Fasanella Rocco, P. O. Box 1001, New Haven, Conn.
Howland, Jonathan, 62 Stanworth lane, Princeton
Hutchinson, William M., 1457 Nott'gh'm W.,Trenton
Matyjasik, Frank M., 518 Centre st., Trenton
McCarthy Joseph F., 615 Beatty st., Trenton
Robinson, Douglas H., N. J. State Hospital, Trenton
Rogers, Edwin D., 2500 Pennington rd., Pennington
Sakson John, 117 Centre st., Trenton
Shipper, Harvey, 949 Berkeley av., Trenton
Weigele, Carl E., 455 W. State st., Trenton
Wise, John S., 73 Westcott rd., Princeton
Yaeger John, Highland av., Yardville

EMERITUS MEMBERS

Davison, Royden W., Miami, Florida
Fell, Alton S., Trenton
Harman, William J., Trenton
Sill, John B., Seaside Park
Turner, Irvine F. P., Titusville

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

ACTIVE MEMBERS

Adler, Howard E., 103 Livingston av., New Bruns'k
Adler, Lydia, 103 Livingston av., New Brunswick
Anderson, John F., 195 College av., New Brunswick
Avery, Philip S., Woodland ter., Bound Brook
Balogh, William A., 315 Dunellen av., Dunellen
Barbano, Alfred J., 225 Hale st., New Brunswick
Barnhardt, Russell A., 10 Deerfield rd., Parlin
Bassett, Lavern C., 320 New Market rd., Dunellen
Becker, Meyer, 219 Amboy av., Metuchen
Becker, Sidney D., 140 Maple pl., Keyport
Belafsky, Henry A., 150 Green st., Woodbridge
Berkow, Bori, 245 State st., Perth Amboy
Berkow, Samuel G., 280 Hobart st., Perth Amboy
Boogdanian, Victor H., 316 George st., N. Brunswick
Borrus, Joseph C., 105 Carroll pl., New Brunswick
Bowman, Ned O., 1001 Georges rd., New Brunswick
Breslow, Samuel, 157 Market st., Perth Amboy
Brezinski, Edward J., 308 Washington st., P. Amboy
Bristol, Frank E., II, Main st., Dayton
Brody, Morton S., 67 Paterson st., New Brunswick
Brown, Milton B., 72 Roosevelt av., Carteret
Budnicki, Xavier B., 105 Broad st., Perth Amboy
Calvin, Charles H., 80 Commerce st., Perth Amboy
Cannata, Benjamin, 113 Market st., Perth Amboy
Church, Charles F., 192 College av., New Brunswick
Clarke, Francis M., 116 New st., New Brunswick
Clinton, James, N. J. State Hospital, Marlboro
Cooper, Irving J., 419 George st., New Brunswick
Cooperman, Eli L., 527 New Brunswick av., Fords
Copleman, Benjamin, 280 Hobart st., Perth Amboy
Copleman, Hyman B., 111 Liv'gst'n av.,NewBruns'k
Cottrell, Judson G., 159 Market st., Perth Amboy
Cowen, Mortimer I., 1330 Oak Tree rd., Iselin
Degenhardt, Ira H., 114 S. First st., Highland Park
Delcau, Marie, 123 Main st., South River
Dieker, Howard E., 78 Main st., South River
Dolin, Joseph, 357 Woodbridge av., New Brunswick
Downing, Perley E., N. J. State Hospital, Trenton
Downs, Louis S., 164 Pershing av., Carteret
Dunham, Malcolm M., 88 Grove av., Woodbridge
Duschock, Edward F., 473 Amboy av., Perth Amboy
Fanelli, Antonio, 494 Compton av., Perth Amboy
Faulkingham, Ralph J., 61 Liv'gst'n av.,NewBr'ns'k
Fazio, Vincent J., 227 Augusta st., South Amboy
Feher, Ladislas A. M., 177 Somerset st., NewBr'ns'k
Fine, Hyman P., 151 Market st., Perth Amboy
Fine, Irvin J., 280 Hobart st., Perth Amboy
Finnegan, William R., Box 191, RFD 5, Nixon
Fishkoff, Alexander H., 132 Market st.,Perth Amboy
Forney, Norman N., 94 N. Main st., Milltown
Forney, Norman N., Jr., Stelle av., Milltown
Frederick, George F., 179 Main st., Woodbridge
Freeman, William S., 117 N. Third av., Highland Pk.
Friedenthal, Bernard, 88 Livingston av.,NewBr'ns'k
Gadek, Stanley A., 95 Fayette st., Perth Amboy
Gerard, Arpad G., 502 Rahway av., Woodbridge
Gessner, Gerard R., 159 New st., New Brunswick
Glasser, Benjamin F., 32 Lindon av., Highland Park
Goldman, Solomon, 161 Livingston av., New Br'ns'k
Gorog, Nicholas M., 159 Bayard st., New Brunswick
Gould, Louis F., 95 Market st., Perth Amboy
Grossman, Walter, 77 Livingston av., N. Brunswick
Gurshman, Sol., 280 Amboy av., Metuchen
Gutowski, Joseph M., 433 Brace av., Perth Amboy
Hamburg, Meyer M., 60 N. Sixth av., Highland Pk.
Hauber, Eugene A., 198 Washington rd., Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hesseltine, Clair E., 305 Main st., South Amboy
Hilker, George F., 258 Maple st., Perth Amboy
Hofer, Clarence J. M., 463 Main st., Metuchen
Hoffman, Charles W., 216 Bordentown av., S. Amboy
Hoffman, Florentine M., 91 Bayard st., New Bruns'k
Howell, E. Gaylord, 120 New st., New Brunswick
Howley, Barth, Jr., 116 Livingston av.,NewBrunsw'k
Hunt, Melvin M., 140 Jackson st., South River
Hurtado, Edward, Redfield Village, Metuchen
Hutner, Cyril I., 134 Grove av., Woodbridge
Ittleman, William S., 307 N. Wash'gt'n av.,Dunellen
Jacobson, Benjamin D., 187 Liv'gst'n av.,N.Br'nsw'k
Jacobson, Murray B., 137 Market st., Perth Amboy
Jasionowski, Edward, 121 Main st., Sayreville
Kant, Emanuel R., 240 High st., Perth Amboy
Karshmer, Nathan, 92 Carroll pl., New Brunswick
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av.,NewBrunsw'k
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Brunswick
Kluft, Jack M., 280 Hobart st., Perth Amboy
Koelsch, Frederick J. E.,14 Kirkpatrick st.,N. Br'ns'k
Kohut, George J., 436 Amboy av., Perth Amboy
Krafchik, Louis L., 158 Livingston av., N. Brunswick
Kramer, Bernard M., 254 State st., Perth Amboy
Kramer, Samuel E., 254 State st., Perth Amboy
Kunderman, Philip J., 215 Harper st., Highland Pk.
Lang, Joseph, 111 Market st., Perth Amboy
Lang, Joseph T., 115 Main st., South River
Lavine, Samuel C., 502 Georges rd., New Brunswick
Lazow, S. Manlius, 199 Main st., Matawan
Leonard, Martha F., 55 N. Fifth av., Highland Park
Levinson, Reuben, 123 Market st., Perth Amboy
Lewis, Collins E., 219 Seaman st., New Brunswick
Lief, Lawrence H., Gatzmer av., Jamesburg
Lind, Zoltan H., 215 Livingston av., New Brunswick
London, Isabel M., 103 N. Fourth av., Highland Pk.
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Brunswick
Lucey, James J., 185 Market st., Perth Amboy
Lutz, Martin H., 130 W. Fifth av., Roselle
Mangogna, Philip, 334 Barclay st., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 280 Hobart st., PerthAmb'y
Marino, Benjamin, 14 Llewellyn pl., N. Brunswick

Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Br'sw'k
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av.,NewBr'ns'k
McKiernan, Robert L., 75 Livingston av.,N.Brunsw'k
McKinstry, John W., Railroad av., Jamesburg
McLaughlin, Thomas F., 19 Durham st., Metuchen
Meinzer, Martin S., 147 Market st., Perth Amboy
Messinger, Samuel, 31 Roosevelt av., Carteret
Miller, S. David, 90 Carroll pl., New Brunswick
Moolten, Sylvan E., 103 N. Fourth av., Highland Pk.
Morgenstern, Mates, 184 Livingston av.,N.Brunsw'k
Morris, Carlyle, Spring street, Metuchen
Nafey, Herbert W., 51 Livingston av., NewBrunsw'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 191 Livingston av., NewBr'ns'k
Niemiera, Alexander K., 509 State st., P. Amboy
Normand, Alphonse F., 267 High st., Perth Amboy
O'Connell, James J., 116 Livingston av., NewBr'ns'k
Panigrosso, Louis R., 455 Lawrie st., Perth Amboy
Pansy, Abraham A., 12 Jackson st., South River
Pellicane, Anthony J., 183 Liv'gst'n av., New Br'ns'k
Perillo, Louis, 638 Amboy av., Perth Amboy
Pickar, Gabriel, 205 N. Second av., Highland Park
Putter, Eric, 180 N. Main st., Milltown
Racz, George, 118 New st., New Brunswick
Reason, John J., 612 Roosevelt av., Carteret
Reitman, Norman, 155 Livingston av., New Brunsw'k
Rineberg, Irving E., 137 Livingston av., NewBr'ns'k
Romano, Frank, 207 Front st., Dunellen
Rona, Maurice, 10 Kirkpatrick st., New Brunswick
Rosenberg, Norman, 10 Lincoln av., Highland Park
Rothfuss, C. Howard, 574 Rahway av., Woodbridge
Rothschild, Karl, 149 Livingston av., New Brunsw'k
Rowland, John H., 159 New st., New Brunswick
Rubin, William, 105 Carroll pl., New Brunswick
Runyon, Laurence P., 80 Somerset st., New Bruns'k
Salaky, William L., 387 Neville st., Perth Amboy
Sandella, Joseph F., 138 Livingston av., N. Brunsw'k
Scalera, John F., 28 S. Plainfield av., S. Plainfield
Schwartz, Albert, 280 Hobart st., Perth Amboy
Scott, Frederick W., 103 Bayard st., New Brunswick
Sender, Fannie, 193 Main st., South River
Shangold, Jack E., 280 Hobart st., Perth Amboy
Shayevitz, Abraham S., 102 Main st., South River
Sherman, W. Edgar, 7 Livingston av.,NewBrunsw'k
Shull, John V., 184 Kearny av., Perth Amboy
Siegel, Ralph E., 111 Market st., Perth Amboy
Silber, Irving M., 94 Schureman st., New Brunswick
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., Perth Amboy
Smith, Charles H., 51 Livingston av., New Brunsw'k
Smith, Ivan B., Georges rd., Dayton
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Marshall, 62 Bayard st., New Brunswick
Smith, Sydney F., 402 Raritan av., Highland Park
Sokoloff, Oscar J., 69 Paterson st., New Brunswick
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theodore D., 102 S. Wash'gt'n av.,Dunellen
Stein, William, 177 Livingston av., New Brunswick
Stollman, Bernard D., 21 John st., New Brunswick
Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 55 Paterson st., N. Brunswick
Thompson, Thomas M., 601 S.First av.,Highland Pk.
Tisch, Leon, 28 S. Third av., Highland Park
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
Tucker, Sidney, 211 Madison av., Perth Amboy
Uhr, Jacques S., 127 Livingston av., New Brunsw'k
Ulan, Jerome, Main st., Spotswood
Urban, George J., Jr., 40 Egan st., Fords
Urbanski, Matthew F., 148 Market st., Perth Amboy
Van Mater, John S., 61 Livingston av., N. Brunswick
Vargyas, Joseph C., 116 New st., New Brunswick
Walker, Otto, 198 Pershing av., Carteret
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 158 Main st., Woodbridge
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 280 Hobart st., Perth Amboy
Wetterberg, Louis F., Amboy av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wiesenfeld, Benjamin, 570 Barron av., Woodbridge
Wiesenfeld, Paul, 138 Market st., Perth Amboy
Wilentz, William C., 188 Market st., Perth Amboy
Winn, James S., 51 Livingston av., New Brunswick
Winn, William M., 128 Broad st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

ASSOCIATE MEMBERS

Benko, George, 266 High st., Perth Amboy
Brady, Edward A., Jr., 11 Stone st., New Brunswick
Brody, Michael, 228 Livingston av., New Brunswick
Cano, Harold V., 391 Main st., Spotswood
Katz, Emanuel, 9 Kirkpatrick st., New Brunswick
Kuhn, William, Mass. General Hosp.,Boston 18,Mass.
Miller, Bernard J., 75 Raritan av., Highland Park
Noble, Paul R., Middlesex General Hosp.,N.Brunsw'k
Novak, Edward J., 61 Green st., Woodbridge
Pisciotta, Frank, 11th and Raritan avs., Highland P.

HONORARY MEMBERS

Burnett, Charles B., South River
Henry, Frank C., Perth Amboy
Spencer, Ira T., Woodbridge
Tyrrell, George W., Perth Amboy

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

ACTIVE MEMBERS

Adler, Samuel, 229 Broad st., Red Bank
Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Baer, Irving, 65 Branch av., Red Bank
Baeseman, R. Winfield, 112 Main st., Allenhurst
Baker, Elsworth F., 58 Reckless pl., Red Bank
Banta, Edward E., 64 Peters pl., Red Bank
Bar, Samuel, Englishtown
Barnett, Lester A., 300 Deal Lake dr., Asbury Park
Barnett, Robert W., 601 Grand av., Asbury Park

Binder, Joseph, 101 Third av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Booth, Herbert W., 4th & Jersey avs., Spring Lake
Bornstein, Paul K., 601 Grand av., Asbury Park
Boyd, John B., 31 Oakland st., Red Bank
Bregman, Milton, 81 Union av., Manasquan
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Kenneth G., 501 Grand av., Asbury Park
Bruzza, George, 415 Washington Blvd., Sea Girt
Burkhead, Howard C., 541 Broadway, Long Branch
Captanian, Aram A., 166 Main st., Matawan
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Casagrande, Stephen R., 56 River rd., Rumson
Ciampa, Ralph P. E., 119 Morris av., Long Branch
Clark, John C., 501 Grand av., Asbury Park
Collis, Abraham S., 156 Atlantic Av., Long Branch
Cooper, Jehu P., Box 74, Matawan
Costa, Philip L., 88 East Front st., Red Bank
Daversa, Benjamin, 209 Passaic av., Spring Lake
Delcau, Jules, 56 W. Main st., Freehold
D'Elia, William J., 1100 Third av., Spring Lake
Demaree, Richard H., 310 Norwood av., W.L'gBr'nch
Dengrove, Edward, 314 Grassmere av., Interlaken
dePons, Sarah C., 501 Grand av., Asbury Park
DeSimone, Louis E., 1110 Grand av., Asbury Park
DeVita, Anthony J., Wilson av., Port Monmouth
Diamond, David I., Oceanport av., Oceanport
Dimitrow, Helen, 236 Broad st., Red Bank
Dorr, Henry B., 1480 Ocean av., Sea Bright
Duvall, Albert I., Broad st., Shrewsbury
Edelson, Samuel, 1611 Grand av., Asbury Park
Ellenson, Solomon S., 507 Fourth av., Asbury Park
Featherston, Daniel F., 601 Grand av., Asbury Park
Feinberg, Harry D., 384 Second av., Long Branch
Feldman, Joel, 64 West Front st., Red Bank
Feman, J. George, 141 Main st., Keansburg
Fenton, Tennant E., 320 Ludlow av., Spring Lake
Ferguson, John, Monmouth Mem. Hosp., L. Branch
Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
George, Amerigo, 153 Third av., Long Branch
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 84 Richmond pl., Deal
Goldberg, Jacob, 155 Franklin av., Long Branch
Goldstein, Benjamin, 320 Asbury av., Asbury Park
Gordon, J. Berkeley, N. J. State Hosp., Marlboro
Graber, Irving, 500 Tenth av., Belmar
Graham, Richard B., 720 Boston Blvd., Sea Girt
Haines, Emerson S., 614 Windermere av., Asbury P.
Halbstein, Bernard M., 138 Bath av., Long Branch
Hancock, Michael Q., Third av. & River rd., Belmar
Hardy, John W., 53 Main st., Farmingdale
Hausman, Samuel W., 50 W. Front st., Red Bank
Haut, Edward M., 21 Main st., Farmingdale
Heatley, William, 29 Drummond pl., Red Bank
Heisen, Aaron J., Imlaystown
Herrman, William G., 501 Grand av., Asbury Park
Heymann, Ernest F., 345 Broad st., Red Bank
Hindle, F. Lawton, 145 Maple av., Red Bank
Hodas, Sidney M., 268 Broad st., Red Bank
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Hummel, Frederick W., 606 F st., Belmar
Isen, Paul J., 600 Third av., Bradley Beach
Jamison, William F., 501 Grand av., Asbury Park
Jarecki, Max M., 905 Bergh st., Asbury Park
Jones, Helen E., 601 Grand av., Asbury Park
Jordan, Joseph C., 238 East Main st., Manasquan
Kahrs-Dreyfors, Madeline, N.J. State Hosp.,Marlb'ro
Kaye, Bernard, 245 Bath av., Long Branch
Kazmann, Harold A., 601 Grand av., Asbury Park
Kelemen, Edward, 875 Broadway, Long Branch
Koch, William, 601 Grand av., Asbury Park
Lehmann, Otto, 138 Bath av., Long Branch
Leonard, Lothair L., 615 Asbury av., Asbury Park
Levin, Jack, 95 W. Main st., Freehold
Lewis, Jacob, 43 Court st., Freehold
Long, Elias E., 85 W. Front st., Red Bank
Lovett, Irving K., 110 E. Front st., Red Bank
Luca, Frank, 563 Westwood av., Long Branch
Luca, Mildred O., 563 Westwood av., Long Branch
Lussier, Georges H., Brisbane Center, Farmingdale
MacKenzie, Robert A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, Daniel V., 55 East Front st., Red Bank
Martin, Leonard J., Box 431, Asbury Park
Matthews, William, 139 Broad st., Red Bank
Mazzei, Armando, 282 Liberty st., Long Branch
McCreight, David W., N. J. State Hosp., Marlboro
McCurdy, Robert G., 74 W. Highland av.,Atl.Highl'ds
McDonnell, George J., 80 W. Main st., Freehold
McGreevey, Harold, 314 Brighton av., Spring Lake
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robert S., 37 E. Wash'gt'n av.,Atl.Highlds
Miele, Frank A., 314 Carr av., Keansburg
Mohair, John P., N. J. State Hosp., Marlboro
Movelle, John, 840 River rd., Fair Haven
Mulligan, Edward W., 81 Shrewsbury av., Red Bank
Nathanson, Norman, 489 Broadway, Long Branch
Neiderhoffer, Sydney L., 469 Broadway, L. Branch
Niemtzow, Frank, 55 East Main st., Freehold
Opfermann, John L., 167 Bay av., Highlands
Osborn, A. Downey, 415 Fourth av., Belmar
Parker, James W., 175 Shrewsbury av., Red Bank
Parry, Oliver K., 601 Bangs av., Asbury Park
Payne, Douglas, Cooper Hospital, Camden
Perrine, Cornelius C., 668 River rd., Fair Haven
Perrotta, Anthony J., 42 Harding rd., Red Bank
Pieper, Howard C., 120 Main st., Keyport
Pietri, Raoul, 501 Grand av., Asbury Park
Pignataro, Frank P., 342 Broad st., Red Bank
Podell, A. Alfred, 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 69 W. Front st., Red Bank
Raffetto, Joseph F., 601 Bangs av., Asbury Park
Reynolds, Donald G., 64 W. Main st., Freehold
Reynolds, George G., 64 W. Main st., Freehold
Rifici, Anthony L., 1010 Grand av., Asbury Park
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, William A., 62 Main av., Ocean Grove
Rocco, Leo C., 75 Maple av., Red Bank
Rosenthal, Abraham, 43 Third av., Atl. Highlands
Rubin, Harold, 601 Grand av., Asbury Park
Rubin, Jacob S., 505 Fourth av., Asbury Park
Rubin, Samuel, 401 First av., Asbury Park
Rullman, Walter A., 58 W. Front st., Red Bank
Rush, Martin R., 326 Broad st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Salmeri, Edward J., 253 River rd., Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmaier, Sica L., 607 Fifth av., Belmar
Schmidt, Albert F., 521 Crescent Parkway, Sea Girt
Schneider, Leonard, 618 Brinley av., Bradley Beach
Sewell, Stephen, 320 Passaic av., Spring Lake
Shanik, William, 601 Grand av., Asbury Park
Shapiro, Saul J., 50 E. Lincoln av., Atl. Highlands
Siegel, Victor, 43 E. Front st., Red Bank
Silverstein, Max, 605 First av., Asbury Park
Slocum, Harry B., 464 Church st., Long Branch
Steller, Frederick C., 220 St. Clair av., Spring Lake
Stevenson, George S., R. D. Box 556, Red Bank
Strahan, Frank G., 473 Broadway, Long Branch
Strauss, Arthur, 130 Pavilion av., Long Branch
Thetford, Norman D., 68 South st., Eatontown
Thompson, Victor, 80 W. Front st., Keyport
Tilley, John A., 165 Main st., Keyport
Tobin, Joseph M., N. J. State Hospital, Marlboro

Toren, Julius A., R. D. 1, Box 95, Long Branch
Trippe, Morton F., 702 Asbury av., Asbury Park
Tyndall, Alice D., 127 Maple av., Red Bank
Upham, Helen F., 305 Third av., Asbury Park
Verga, Armand, 20 Main st., Manasquan
Villapiano, Joseph G., 701 Sunset av., Asbury Park
Von Oehsen, William H., 623 4th av., Bradley Beach
Wainright, Melvin A. R., 286 Broad st., Red Bank
Weinstein, Alvin, 300 Deal Lake dr., Asbury Park
Whelan, Vincent, 67 E. Front st., Red Bank
Wilbur, Franklin L., 515 Eighth av., Asbury Park
Wiley, Herman O., 326 Shrewsbury av., Red Bank
Wilkins, Stanley O., 47 E. Front st., Red Bank
Willey, Harry S., Jr., 112 Broad st., Red Bank
Wilson, Robert B., 48 Riverside av., Red Bank
Winder, Miles S., Jr., 602 Blanchard Pky.,W.Al'nh'st
Woodruff, Ralph G., Main st., Englishtown

ASSOCIATE MEMBERS

Bowne, Donald W., 1300 Sunset av., Wanamassa
Clark, John J., 517 Broadway, Long Branch
DeRosa, Vincent A., 31 Oakwood av., Long Branch
DeVito, Alfred T., 405 La Reine av., Bradley Beach
Ellis ,William C., 69 West Front st., Red Bank
Estrin, Seymour S., 300 Main st., Bradley Beach
Evans, H. Walter, Jr.,Fitkin Memor'l Hosp.,Neptune
Fisher, James A., Jr., 601 Grand av. Asbury Park
Gilmour, Thomas J., Jr., 19 Maple av., Keansburg
Glaus, Samuel D., 328 Lincoln av., Avon
Herbert, William A., 501 Washington av., Avon
Hines, Harrison R., 710 Grand av., Asbury Park
Mosig, John J., Asbury Vets. Garden Apts., Belmar
Nicas, Allen M., 450 Broadway, Long Branch
Parker, James W., Jr., 179 Shrewsbury av.,Red Bank
Robertson, Robert B., 69 Maple av., Red Bank
Samaha, Charles, 7 Sunset dr., Asbury Park
Sheehan, George A., 27 Irving pl., Red Bank
Sinnott, John, Jr., Rumson rd., Rumson
Vaccaro, Henry J., 509 Fourth av., Asbury Park
West, Harold, 606 F st., Belmar
White, Ensley M., Jr., 15 St. Nicholas pl., Red Bank

COURTESY MEMBERS

Benedict, Mitchell M., Fort Monmouth
Fazio, Vincent J., South Amboy
Knowles, Frederick, Sea Girt
Navarra, Simone, Rumson

HONORARY MEMBERS

Barber, Robert F., Farmingdale
Donovan, William F., Brielle
Hill, John A., Allenhurst
Jones, Granville L., Williamsburg, Virginia
Ransohoff, Nicholas S., Long Branch
Stewart, Edwin F., Fair Haven
Thomas, Harry G., New York
Worthington, Joseph A., Bradley Beach

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

ACTIVE MEMBERS

Alcaro, Joseph A., 2 Perry st., Morristown
Baker, Augustus L., 389 W. Blackwell st., Dover
Baker, Augustus L., Jr., 389 W. Blackwell st., Dover
Beard, James R., Jr., Taff dr., Millington
Beaver, Jennie D., 44 Elm st., Morristown
Benz, Francis J., 30 Lum av., Chatham
Bertha, Nicholas A., 83 S. Main st., Wharton
Bird, Frank L., 8 Main st., Netcong
Bird, Frank L., Jr., 8 Main st., Netcong
Blake, Dexter B., R. F. D. 1, Far Hills
Bobadilla, Juan E. B., 293 S. Main st., Wharton
Booth, William K., 304 William st., Boonton
Borkow, Philip, 45 E. Blackwell st., Dover
Bowers, F. Clyde, Mountain av., Mendham
Breuder, Andrew B., Whippany rd., Whippany
Byrne, J. Arthur, 16 Elm st., Morristown
Coggeshall, Bayard, 20 Elm st., Morristown
Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N.J. State Hosp.,Greyst'ne P'k
Comeau, George W., 415 Speedwell av.,Morris Plains
Cook, Dora G., 317 Cornelia st., Boonton
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison
Cummins, Ella F., 39 Elm st., Morristown
Curry, Marcus A., N. J. State Hosp., Greystone Park
Day, Kenneth L., 14 Elm st., Morristown
DeFelice, Mario T., 790 E. Clarke pl., Orange
DeGregorio, Peter J., 56 Prospect st., Madison
Deichman, Charles H., 39 Elm st., Morristown
Dirdack, Morris, 12 James st., Morristown
Donovan, Joseph, N. J. State Hosp., Greystone Park
Dwyer, Gregory, Community Med. Group, Boonton
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
Emory, George B., Jr., 1 Franklin pl., Morristown
Esposito, Amedeo C., N. J. State Hosp.,GreystonePk.
Evans, Edgar J., 25 Second av., Denville
Failmezger, Theodore R., 125 Green av., Madison
Falvello, Nicholas A., Box 122, Deerfield Beach, Fla.
Faraci, Charles, 23 Diamond Spring rd., Denville
Ferriss, Ruth B., 8 Wetmore av., Morristown
Finby, Nathaniel, 46 Main st., Netcong
Foley, James G., Craig st., Basking Ridge
Forestiere, Jasper, 10 Park pl., Morristown
Gambill, Perry J., N. J. State Hosp., Greystone Park
Gantt, Margaret H., 43 Hillcrest rd., Madison
Gebirtig, Theodore, 181 South st., Morristown
Gianni, Angelo R., 37 Main st., Netcong
Gilbertson, Robert L., 26 Maple av., Morristown
Giordano, Salvatore, 13 DeHart st., Morristown
Glazebrook, Francis H., "HoneysuckleW'ds,"Rumson
Gordon, Charles D., Mt. Arlington
Graft, Richard S., 44 Green av., Madison
Grant, Raymond J., 117 S. Main st., Wharton
Gregory, Marie F., 50 Green Village rd., Madison
Hampton, George R., N.J. State Hosp.,GreystonePk.

Harrington, J. Henry, 40 E. Main st., Rockaway
Hatch, Harold S., Shonghum Mt. Sana., Morristown
Haut, Gail W., 32 General Wayne Village, Madison
Hiler, Stuart A., 62 Rockaway av., Rockaway
Hogan, Marshall D., 311 W. Main st., Boonton
Hopper, John B., E. Main st., Mendham
Hopping, John S., River rd., Hanover
Hornick, Emil E., 6 Altamont ct., Morristown
Hubert, Antonio O., 131 E. Main st., Rockaway
Ivey, Evelyn P., 3 Community pl., Morristown
Kelly, J. Paul, 30 Ridgedale av., Morristown
Kent, Donald F., 396 Main st., Chatham
King, Alden P., 400 W. Blackwell st., Dover
Klein, Solomon, 11 High st., Morristown
Krauss, Fletcher I., 407 Main st., Chatham
Kuite, George B., 435 Speedwell av., Morris Plains
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, George H., 965 Broad st., Newark
Laudig, Guy H., 361 Speedwell av., Morris Plains
Levendusky, Daniel E., 20 W. Main st., Rockaway
Lewin, Leo, Howard Blvd., Mt. Arlington
Luddecke, Hugh F., 40 Franklin st., Morristown
Luippold, Eugene J., Jr., 130 Fairview av., Boonton
MacGregor, Mary E. C., 242 Fairmount av., Chatham
Mathews, Raymond H., 186 South st., Morristown
McMahon, Bernard C., 15 James st., Morristown
McMurtrie, William A., 20 Franklin st., Morristown
Melvin, Daniel G., N. J. State Hosp., Greystone Park
Mills, Clifford, 36 Maple av., Morristown
Mintz, Alvin R., 32 Maple av., Morristown
Musetto, Carmelo A., 135 Cornelia st., Boonton
Navazio, Attilio, 29 DeHart st., Morristown
Oestreicher, Harry, Picatinny Arsenal, Dover
Parry, Allen A., 54 Green av., Madison
Parry, Antoinette R., 54 Green av., Madison
Patton, Paul B., 3 Winding Way rd., Morris Plains
Pinckney, Frank H., 186 South st., Morristown
Pottinger, William E., 6 Altamont court, Morristown
Prager, Bert A., 511 Main st., Chatham
Reilly, John T., 18 DeHart st., Morristown
Renna, Francis, 20 Morris av., Morristown
Rice, Franklin W., 184 South st., Morristown
Rosen, Herbert J., 42 Hudson st., Dover
Rosenberg, Alvin A., 22 High st., Morristown
Rubens, Otto, 153 E. Blackwell st., Dover
Ryman, Merlin T., 5 Dunbar st., Chatham
Sagert, Carl M., 18 Old Wood rd., Morris Plains
Saltus, Lloyd S., 16 Elm st., Morristown
Schumacher, Evelyn L., 32 Maple av., Morristown
Seward, Frederic H., 40 Green Village rd., Madison
Shanik, Morton J., 55 W. Blackwell st., Dover
Spencer, Alvan, 395 W. Blackwell st., Dover
Spitzhoff, Frederick M., Succasunna
Stage, Earl DeW., 36 Maple av., Morristown
Talmage, William G., Main st., Succasunna
Teller, Daniel W., Jr., 28 DeHart st., Morristown
Terreri, D. Joseph, 30 High st., Morristown
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 18 Elm st., Morristown
Truax, Alfred J., Main st., Chester
Van Wiemokly, Seymour S.,201 Speedw'l av.,Morrist'n
von Deilen, Henry O., 28 DeHart st., Morristown
Voss, J. Landon, 212 South st., Morristown
Wade, Francis A., 12 Mount Kemble av.,Morristown
Ward, Albert J., 39 Elm st.. Morristown
Weiss, Herman, 300 Madison av., Madison
Wichman, Heins, 28 DeHart st., Morristown
Williams, David P., 116 Lake dr., Mountain Lakes
Woodman, Charles B., 212 South st., Morristown
Young, George J., 60 Maple av., Morristown
Ziegler, James E., 28 Mt. Airy rd., Bernardsville
Zimmerman, Robert F., 28 Wash'gton av.,Morrist'n
Zuloff, D. Blair, 3 Community pl., Morristown

COURTESY MEMBERS

Morrison, John T., Mountain Lakes
Thorburn, Grant, Brookside

HONORARY MEMBERS

Baker, Augustus L., Dover
Beaver, Jennie D., Morristown
Costello, William F., Dover
Coultas, Aldo B., Madison
Curry, Marcus A., Greystone Park
Glazebrook, Francis H., Rumson
Gordon, Charles D., Mt. Arlington
Hampton, George R., Greystone Park
Krauss, Fletcher I., Chatham
Lathrope, George H., Newark
Mills, Clifford, Morristown
Prager, Bert A., Chatham
Seward, Frederic H., Madison

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Aipert, Sidney, 321 Second st., Lakewood
Appleton, Ralph, Lincoln av., Point Pleasant
Blumberg, A. William, New Egypt
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Camarda, Joseph, P. O. Box 215, Lakehurst
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, William E., Ocean st. & Bay av., Beach Haven
Dwulet, Leon, 910 Arnold av., Pt. Pleasant
Gartlan, Bernard W., 405 Main st., Toms River
Gebele, William X., Jr., 421 Second st., Lakewood
Goldstein, Abraham, 404 Madison av., Lakewood
Gove, Richard R., Jr., 46th & Blvd., Brant Beach
Green, Thomas J., New Egypt
Henriksen, J. Bruce, 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Lehmacher, Frank, 16 Central av., Lakewood
McDonald, Andrew, Richmond av., Pt. Pleasant
Menge, Carl H., 236 Washington st., Toms River
Mitchell, Willis B., Holly Cranmoor Manor, Toms R.
Nyvall, Pierre J., 9 Maple av., Barnegat
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., 212 Washington st., Toms River
Rinzler, Harvey, 614 Main st., Toms River
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., Cedar av., Tuckerton
Sickel, Emanuel M., 318 Forest av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Wentz, Irl Z., 224 Webster av., Seaside Heights
Witte, C. Norman, 422 River av., Point Pleasant
Zinkin, Solomon B., 328 Second st., Lakewood

PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on third Tuesday of each month except June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Abramo, Anthony E., 141 Glen av., Midland Park
Ackerhalt, Martin J., 408 Clifton av., Clifton
Adler, Fritz F., 777 Market st., Paterson
Allen, Arthur A., 365 Park av., Paterson
Allen, Edwin J., 269 Carroll st., Paterson
Allen, James M., 585 Main st., Passaic
Alonzo, Gerard J., 477 Stuyvesant av., Lyndhurst
Alpren, Bernard F., 17 Church st., Paterson
Ambrose, Francis, 377 Park av., Paterson
Andrews, Albert G. K., P. O. Box 743, Passaic
Apter, Abraham H., 45 Church st., Paterson
Aronsohn, Charles M., 459 Park av., Paterson
Ash, Frank W., 180 Carroll st., Paterson
Atwood, Edward A., 360 Park av., Paterson
Averbach, Jacob, 435 Clifton av., Clifton
Balles, Edward S., 392 Park av., Paterson
Barlow, Frank A., Veterans Hosp., Bay Pines, Fla.
Barnett, Jack, 388 12th av., Paterson
Barolsky, Benjamin, 452 15th av., Paterson
Barone, Leo J., 392 Van Houten st., Paterson
Barr, Joseph, 975 Madison av., Paterson
Battin, Richard P., 149 Prospect st., Passaic
Baxt, Sidney J., 544 21st av., Paterson
Becker, George L., 646 E. 28th st., Paterson
Becker, Leo V., 69 Ward st., Paterson
Beim, Norbert, 669 Broadway, Paterson
Bender, Theodore, 666 Broadway, Paterson
Benjamin, Joseph F., 203 Godwin av., Ridgewood
Berk, M. David, 505 Wanaque av., Pompton Lakes
Berkhout, Peter G., 106 Haledon av., Prospect Park
Berner, Benjamin, 465 Park av., Paterson
Bernson, Samuel T., 505 Wanaque av., Pompton L.
Biczak, Arkad K., 311 Lexington av., Clifton
Blake, Albert J., 640 Broadway, Paterson
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bornstein, David, 566 Broadway, Paterson
Botbyl, Burt W., 927 Madison av., Paterson
Brancone, Alphonse M., 417 21st av., Paterson
Brawer, Jerome, 425 Park av., Paterson
Brill, Robert, St. Mary's Hospital, Passaic
Brogan, Francis B., 600 Broadway, Paterson
Bromberg, Charles B., 107 Lexington av., Passaic
Bronner, Alfred, 47 Burgess pl., Passaic
Brooks, Sidney S., 380 12th av., Paterson
Budd, J. Reuben, 230 Lexington av., Passaic
Buklad, Henry P., 441 Broadway, Passaic
Bullen, Victor E., 148 Hamilton av., Paterson
Butterfield, Arey A., 655 Main av., Passaic
Calligaro, Egildo A., 288 Parker av., Clifton
Canaan, Robert, 12-18 River rd., Fair Lawn
Capell, Harry H., 302 Broadway, Paterson
Capio, Mario D., 293 Broadway, Paterson
Carlough, David J., 426 Ellison st., Paterson
Carusl, Leonardo G., 337 Park av., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
Chapnick, Maurice M., 715 Broadway, Paterson
Charney, William, 555 Broadway, Paterson
Cherry, Homer H., Valley View Sana., Paterson
Chester, Saul W., 634 Broadway, Paterson
Chilton, Forrest S., Pompton Tpk., Pompton Plains
Chrisman, Irving, 423 Broadway, Paterson
Chudzik, Edward W., 269 Outwater lane, Garfield
Churg, Jacob, Barnert Memorial Hosp., Paterson
Ciccone, Anthony C., 389 Grand st., Paterson
Ciccone, Roy, 57 Passaic av., Passaic
Cichon, Elmer J., 679 Van Houten av., Clifton
Clark, Orlo H., 149 Prospect st., Passaic
Close, Byron H., Hamburg Turnpike, Bloomingdale
Cohen, Julian, 592 E. 29th st., Paterson
Cohen, Louis, 257 Paulison av., Passaic
Cohen, M. Marvin, 582 E. 25th st., Paterson
Cohn, Isidor, 231 Lexington av., Passaic
Cole, L. Frank, 388 Terhune av., Passaic
Colfax, Richard S., 33 Bartolf av., Pompton Lakes
Connolly, Joseph P., 56 Hamilton st., Paterson
Conserva, Peter V., 196 Randolph av., Clifton
Cortese, Alvin E., 26 Ward st., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crescente, Fred J., 836 Madison av., Paterson
Crounse, David R., 84 Broadway, Passaic
Curtis, A. Maurice, 445 Van Houten st., Paterson
Davis, A. Hobson, Paterson General Hosp., Paterson
Dawson, Harry, 618 E. 24th st., Paterson
DeBell, Peter J., 65 Summer st., Passaic
DeDominicis, Frank A., 116 17th av., Paterson
DeGrace, Francis H., 311 Paulison av., Passaic
Deich, Samuel R., 170 Passaic av., Passaic
Delario, Anthony J., 316 Broadway, Paterson
Della Penna, Samuel J., 320 Ramapo av., Pompton L.
Del Mauro, Alphonse, 460 Park av., Paterson
DeLuccia, Ralph L., 428 Park av., Paterson
DeMattia, Michael, 71 Ward st., Paterson
Denison, Ward C., 316 Broadway, Paterson
DeRosa, Armand, 262 Totowa rd., Totowa
Desmet, Victor F., 324 Broadway, Paterson
De Yoe, Leon E., 602 Broadway Paterson
Dingman, Norman M., 330 Broadway, Paterson
Dirr, John P., 785 Main av., Clifton
Doktor, David, 648 14th av., Paterson
Donnelly, Joseph E., 445 Market st., Paterson
Drake, Daniel E., Union Valley rd., Newfoundland
Dren, George W., 191 Lexington av., Passaic
Duncan, Owsley B., 414 Ellison st., Paterson
Dwyer, Henry E., 261 Madison st., Passaic
Dwyer, William A., 99 Park av., Paterson
Edlkraut, Edward C., 320 Lexington av., Clifton
Edson, James, 336 Belmont av., Haledon
Ehrenfeld, Edward, 185 Lexington av., Passaic
Ehrenfeld, Irving, 185 Lexington av., Passaic
Ehrlich-Morrow, Laura E., 197 Passaic av., Passaic
Eisemann, Jerome S., 38 Main st., Butler
Esposito, Anthony L., 246 Lexington av., Passaic
Farber, Herbert R., 675 Broadway, Paterson
Farkas, Gustav, 255 Harrison st., Passaic
Feliciano, Vincent, 286 Lafayette av., Hawthorne
Fenster, Morton N., 202 Lexington av., Passaic
Fenwick, John R., 196 Lakeview av., Clifton
Ferrari, Salvatore, 372 21st av., Paterson
Ferrary, Paul B., 80 Park av., Paterson
Fielding, William M., 15 Waldwick av., Waldwick
Fisher, Samuel, 808 Madison av., Paterson
Foote, Sherman K., Clinton av., Wyckoff
Fortay, Steven O., 474 Park av., Paterson
Fortuin, Floyd, 434 Park av., Paterson
Fraulo, Louis, 241 Crooks av., Clifton
Freedman, Jacob S., 178 Hamilton av., Passaic
Friedman, Edna C., 732 E. 26th st., Paterson
Friedmann, Gustav, 425 Park av., Paterson
Gallardo, Agustin, 61 Lakeside av., Pompton Lakes
Gallo, James S., E. Allendale av., Saddle River
Gannon, John R., Passaic General Hospital, Passaic

Garnett, Robert, 285 Lexington av., Passaic
Ged, Archie K., 1133 Main st., Paterson
Geiger, Harold C., Main st., West Milford
Geller, Joseph J., 137 Ellison st., Paterson
Gellman, William B., 163 Valley Blvd., Wood-Ridge
Gelman, Sidney, 600 E. 27th st., Paterson
Gerson, Stanley, 480 Park av., Paterson
Giambra, Sante M., 400 Park av., Paterson
Giglio, Louis A., 610 East 27th st., Paterson
Ginsburg, Samuel, 227 Paulison av., Passaic
Gochman, Harry M., 166 Hamilton av., Paterson
Goldenberg, Raphael R., 588 E. 27th st., Paterson
Golding, Harry N., 180 Carroll st., Paterson
Goldstein, Edward W., 561 E. 28th st., Paterson
Golish, Harry L., 425 15th av., Paterson
Gordon, Abel, 616 Main av., Passaic
Gordon, Samuel, 540 Park av., Paterson
Gordon, William, 648 Ringwood av., Wanaque
Gormley, Cyrus M., 320 Broadway, Paterson
Gould, John H., 92 Monte Vista av., Ridgewood
Graeter, F. Albert, 43 Barry pl., Passaic
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 279 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Greenwell, Albert W., 6 S. Brookwood dr., Montclair
Grossbard, Paul, 211 Lexington av., Passaic
Guarraia, Joseph, 106 Florence av., Hawthorne
Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne
Hall, Wayne W., 515 Broadway, Paterson
Halnan, John J., Jr., 631 Madison av., Paterson
Hatem, Elias J., 1046 Main st., Paterson
Hathaway, George, Jr., 149 Prospect st., Passaic
Hayman, Irving R., 681 Broadway, Paterson
Herman, Isadore, 119 Quincy st., Passaic
Hillmann, Frederick C., 64 Hamilton st., Paterson
Hochman, Alex, 260 Hamilton av., Paterson
Hollingsworth, H. Hale, 86 First st., Clifton
Holmes, Thomas J. E., 151 Fair st., Paterson
Holster, Stephen G., 951 Madison av., Paterson
Holt, Herman H., 576 Broadway, Paterson
Hughes, J. Vernon, P. O. Box 454, Passaic
Ianacone, John A., 310 Fifth av., Paterson
Insolera, John A., 388 Park av., Paterson
Iraggi, James V., 53 Passaic av., Passaic
Izenberg, David, 555 E. 29th st., Paterson
Jaffe, Hyman, 149 Broadway, Passaic
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jehl, Joseph R., 59 Harding av., Clifton
Joelson, Dora, 485 Park av., Paterson
Joelson, Morris S., 577 Broadway, Paterson
Joffe, Philip M., 556 E. 28th st., Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 149 Prospect st., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Jurewicz, Stanley T., 290 - 17th av., Paterson
Kaletkowski, Marion F., 4 Englewood rd., Clifton
Kaplan, Sidney, 285 Lexington av., Passaic
Kassel, Mortimer H., 34 Elmwood ct., East Paterson
Katz, Harry, 494 Park av., Paterson
Katz, Herbert I., 44A Boulevard, E. Paterson
Keating, Charles A., 177 Ellison st., Paterson
Keating, Joseph M., 657 Main av., Passaic
Keith, Theodore R., 159 Passaic av., Passaic
Keller, Michael L., 673 E. 27th st., Paterson
Kelley, Ray H., 72 Wyckoff av., Midland Park
Kennedy, A. Andrew, 121 Hadley av., Clifton
Kennedy, Eugene T., 413 Wanaque av.,PomptonLks.
Kerr, Andrew D., Jr., 19 Lincoln av., Clifton
Kim, Gay B., 703 Main st., Paterson
Klein, Alfred, 6-25 Plaza rd., Fair Lawn
Kleiner, Samuel, 162 Hamilton av., Paterson
Kleinmann, Eberhart H., 560 Broadway, Paterson
Klughaupt, Dorothy K., 257 Boulevard, Passaic
Koenig, Bertram, 282 Broadway, Paterson
Koerber, George, 136 Prospect st., Passaic
Korman, Arnold, 24 Dey st., Clifton
Kovaleski, Walter A., 77 Market st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
Krakower, Alvin H., 528 E. 29th st., Paterson
Krugman, Benjamin M., 438 Park av., Paterson
Kulick, Morton, 731 14th av., Paterson
Kurtz, Gerald I., 306 Broadway, Paterson
Laauwe, Harold W., 500 Market st., Paterson
Landaw, Louis, 631 E. 26th st., Paterson
Lang, Richard E., 463 Passaic av., Passaic
Lawless, Edward T., 105 Clarewill av., Up. Montclair
Lawrence, Elias D., 499 Park av., Paterson
Leach, John E., 274 Carroll st., Paterson
Legg, George E., 666 Broadway, Paterson
Lemay, Albert T., 532 14th av., Paterson
Levine, David B., 647 Broadway, Paterson
Levine, Sidney C., 500 Market st., Paterson
Levinsohn, Sandor A., 656 East 29th st., Paterson
Levy, David, 586 E. 29th st., Paterson
Levy, Herman, 158 Lexington av., Passaic
Lima, John G., 292 Broadway, Paterson
Linares, A. Carfi, 208 Market st., Paterson
Lipton, Louis, 67 Passaic av., Passaic
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 184 Lexington av., Passaic
London, Leslie, 120 Lexington av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First av., Little Falls
Mabee, John R., 24 Center av., Little Falls
MacGahan, William H., 1 Main st., Butler
MacGregor, Allan W., 379 Ellison st., Paterson
Mackler, Meyer E., 627 E. 24th st., Paterson
Maclay, Joseph A., 239 Broadway, Paterson
Maffongelli, Joseph A., 311 Broadway, Paterson
Magnes, Max, 555 15th av., Paterson
Manly, Thomas E., 390 Park av., Paterson
Manrodt, Kurt, Jr., New'k-Pompt'n Tpk.,Pompt'n P.
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 450 Park av., Paterson
Markowitz, Louis, 380 Park av., Paterson
Marrocco, William A., 445 Park av., Paterson
Martin, Theodore, 577 Lincoln av., Glen Rock
Masucci, Alberico, 128 Carroll st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
McBride, Andrew F., Jr., 655 Broadway, Paterson
McCarthy, George L., 506 Union av., Paterson
McCue, John B., 118 Lenox av., Pompton Lakes
McDonald, Richard J., 80 Park av., Paterson
McPherson, Malcolm E., 141Diam'd Br.av.,H'wth'rne
Meer, Nadhim E., 338 Park av., Paterson
Meier, William U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Meneve, Alfred D., 320 Broadway, Paterson
Meyers, Francis R., 604 E. 28th st., Paterson
Michelson, Henry, 675 E. 24th st., Paterson
Missonellie, William, 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Monaloy, Morris A., 414 Passaic av., Passaic
Morici, Theodore, 80 Howe av., Passaic
Morrill, James P., Jr., 310 Broadway, Paterson
Morrow, J. Lloyd, 197 Passaic av., Passaic
Moscoe, Harry A., 542 Broadway, Paterson
Mott, Joseph E., 426 Park av., Paterson
Murn, Charles J., 48 Smith st., Paterson
Nemirow, Martin, 162 Lexington av., Passaic
Nesbitt, Elizabeth, N. Jersey Tr'n'g Sch'l,LittleFalls
Nimaroff, Harold, 152 Market st., Passaic
Notkin, Meyer, 559 Broadway, Paterson
Nowak, Emil, 738 Market st., Paterson
Nussbaum, Nathan, 237 Lakeview av., Clifton
Nuzzolo, Charles A., 400 Park av., Paterson
O'Brian, Dennis M., 154 Lexington av., Passaic

O'Brian, Jeremiah H., 661 Main av., Passaic
Offenkrantz, Freder'k M., St. Joseph's Hosp., Pat's'n
Ogden, Michael A., 20 Grove st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Opper, Philip, 606 E. 26th st., Paterson
Oram, Joseph H., 495 Broadway, Paterson
Ozier, Charles W., 223 Autumn st., Passaic
Palma, Nicholas, 20 Hillside av., Glen Rock
Palmer, Francis R., 220 Lexington av., Passaic
Palmeri, Anthony, 111 Chelsea rd., Clifton
Paris, William, 518 E. 25th st., Paterson
Pasquariello, Peter, Totowa rd., Totowa
Pasternack, Elroy, Barry Gardens, Passaic
Patella, Fulvio, 324 Broadway, Paterson
Pernetti, Anthony M., 400 Park av., Paterson
Phelps, James E., 203 Park av., Paterson
Piasecki, Chester A., 585 E. 29th st., Paterson
Pinck, Bernard, 100 Passaic av., Passaic
Pink, Solomon H., 21 High st., Butler
Pizzi, Peter J., 245 Passaic av., Passaic
Plinke, Fritz W., 663 Main av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Pollock, Theodore, 64 Grove st., Passaic
Polowe, David, 555 E. 27th st., Paterson
Prince, Robert A., 567 Broadway, Paterson
Provisor, Benjamin, 271 Lexington av., Passaic
Raab, Michael, 250 Lexington av., Passaic
Randazzo, Anton P., 82 Prospect st., Passaic
Rasin, Carl, 158 Lexington av., Passaic
Rauschenbach, Paul E., Jr., 612 E. 29th st., Paterson
Reading, H. Eugene, 535 E. 29th st., Paterson
Reeves, Ernest, 195 Lexington av., Passaic
Reilly, Thomas F., 127 Union av., Clifton
Reinhorn, Abraham J., 597 E. 27th st., Paterson
Reinkraut, Arthur D., 175 Broadway, Passaic
Ressetar, Michael, 455 Lexington av., Clifton
Riccobono, Cosmo S., 334 Park av., Paterson
Rinzler, Harry G., 127 Van Houten av., Passaic
Rizzo, Ettore G., 352 Van Houten st., Paterson
Robertson, Eugene V., 17 Arlington av., Hawthorne
Roemer, Jacob, 591 E. 27th st., Paterson
Rogers, James A., 274 Carroll st., Paterson
Romano, Michael J., 2 Arlington pl., Radburn
Rosenberg, Marvin, 174 Gregory av., Passaic
Ross, Peter W., 655 Main av., Passaic
Rothenberg, Friedrich, 395 Ellison st., Paterson
Roy, Joseph N., 95 17th av., Paterson
RuBacky, Joseph F. A., 61 Passaic av., Passaic
Ruocco, William B., 416 River st., Paterson
Ruoff, Andrew C., III, 24 Cleveland av., Rivervale
Sabarese, Theodore C., 122 Marsellus pl., Garfield
Saco, Louis S., 922 Main st., Paterson
Saffron, Morris H., 292 Paulison av., Passaic
Sala, Aldo W., 172 Randolph av., Clifton
Salerno, Louis, 973 Van Houten av., Clifton
Salter, Kent, Valley View Sana., Paterson
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 313 18th av., Paterson
Santoro, Anthony, 472 12th av., Paterson
Sarokhan, Joseph, 771 Madison av., Paterson
Schafer, Marguerite A., 298 D'mondBr.av.,H'wth'rne
Schefrin, Alexander E., 235 Lexington av., Passaic
Scheip, James R., II., 343 S. Pleasant av., Ridgew'd
Schleifer, Arnold, 10-04 River rd., Fair Lawn
Schlossberg, Ezra, 156 Amsterdam av., Passaic
Schnee, Isadore M., 586 E. 25th st., Paterson
Schubert, Roy R., 466 Park av., Paterson
Schultz, Augustin M., 379 Union av., Paterson
Schultz, Irving A., 31-11 Broadway, Warren Point
Schwartz, Jacob R., P. O. Box 305, Fair Lawn
Schwartz, Leo, 301 Harrison st., Passaic
Schwartz, William, 224 Lexington av., Passaic
Schwartzberg, Frederick I., 522 Broadway, Paterson
Schwarz, Julianna L., 115 Prospect st., Passaic
Scielzo, Nicholas F., 369 Park av., Paterson
Scillieri, John, 660 Broadway, Paterson
Scovern, Louis, 299 Main av., Passaic
Selikoff, Irving, 707 Broadway, Paterson
Shapiro, Joseph S., 314 Fair st., Paterson
Shapiro, Louis G., 375 Broadway, Paterson
Shechtman, Abraham, 37 Grove st., Passaic
Sheft, Matthew J., 112 Lexington av., Passaic
Shier, Julius M., 585 Main av., Passaic
Shinefeld, Maurice A., 675 Broadway, Paterson
Shipman, Meyer P., 575 Broadway, Paterson
Shulman, Abraham, 528 E. 29th st., Paterson
Siciliano, Thomas, 6 Clinton av., Clifton
Silver, Michael W., 718 E. 25th st., Paterson
Silverman, Irving A., 164 Randolph av., Clifton
Simkin, Abraham, 232 Broadway, Passaic
Simon, Philip H., 174 Columbia av., Passaic
Siss, Alfred A., 198 Haledon av., Prospect Park
Sloan, Samuel L., 182 Belmont av., Paterson
Small, Louis, 101 Prospect st., Passaic
Smith, Elroy W., 309 E. DeLido dr., Miami B'ch,Fla.
Smith, Leon A., 655 Main av., Passaic
Smolev, Joseph M., 585 Main av., Passaic
Snell, Philip, 217 Paulison av., Passaic
Sobel, I. Jerome, 136 Broadway, Passaic
Sporer, Andrew, 707 Broadway, Paterson
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson
Stein, Harriet N., 620 Ridge rd., Lyndhurst
Stern, Morris H., 439 Clifton av., Clifton
Stier, Howard W., 657 Main av., Passaic
Stokes, James S., 32 Main st., Little Falls
Stoltz, Raymond R., 23 Passaic av., Passaic
Stouter, Francis L., 661 E. 18th st., Paterson
Strully, Leonard V., 660 Broadway, Paterson
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, William M., Jr., 43 Passaic av., Passaic
Surgent, George W., 1074 Van Houten av., Clifton
Szafir, Paul, Veterans Administration, Lyons
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 292 Broadway, Paterson
Tarchiani, Lucius S., 472 River st., Paterson
Tarta, Ciro S., 654 E. 18th st., Paterson
Taylor, Halley B., Jr., 221 Hamilton av., Paterson
Teichholz, Max H., 19 Meade av., Passaic
Tell, M. Edward, 249 Lexington av., Passaic
Thomas, Irene O., 350 Lafayette av., Hawthorne
Thomas, Leon H. S., 631 E. 22nd st., Paterson
Thompson, Edward C., 373 Park av., Paterson
Thompson, Walter A., 714 Ackerman av., Glen Rock
Thorne, William P., 254 Main st., Butler
Thron, Leopold E., 791 Broadway, Paterson
Tomkins, William, 105 Fairmount rd., Ridgewood
Trilling, Leonard J., 423 Broadway, Paterson
Tweddel, George K., 239 Broadway, Paterson
Udinsky, Hyman J., 57 Passaic av., Passaic
Urie, Murray G., 394 E. 30th st., Paterson
Vanderbeck, James J., 123 Prospect st., Ridgewood
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vanderbeek, Frank B., 683 E. 27th st., Paterson
Vander Bush, Edward F., 534 E. 29th st., Paterson
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Van Schott, Gerard J., Jr., 245 Lex'gton av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Varhol, Joseph G., 436 Clifton av., Clifton
Vermeulen, Abram, 344 Haledon av., Prospect Park
Vernaglia, Anthony P., 418 Lincoln av., Hawthorne
Vogel, Wolfgang F., 546 E. 29th st., Paterson
Vosburgh, Fred, 663 Main av., Passaic
Vreeland, Ralph J., 278 McKinley pl., Ridgewood
Walker, Harold G., 252 Everett av., Wyckoff
Wallace, Marc J., 165 Lakeview av., Clifton
Walton, Gordon G., 575 E. 28th st., Paterson
Warburton, Jack C., 333 Park av., Paterson
Warren, David E., 48 Rutgers pl., Passaic

Warren, Earl L., Box 1738, Paterson
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weiner, Aaron, 660 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, William L., 400 Broadway, Paterson
Weisman, Stephen L., 526 Broadway, Paterson
Westerhoff, Peter D., 51 Highland av., Midland Park
Williams, Hiram, P. O. Box 266, Montclair
Winters, Walter M., 288 Broadway, Paterson
Wolf, Erich, 43 Grove st., Passaic
Wolf, Israel J., 231 East 31st st., Paterson
Wolfson, Harry, 356 Park av., Paterson
Wry, Dean A., 234 Dayton av., Clifton
Yachnin, Samuel C., 127 Prospect st., Passaic
Yager, J. Allen, 420 Broadway, Paterson
Yates, John S., 414 Ellison st., Paterson
Yeaw, Ralph C., 310 Broadway, Paterson
Yolken, Harry, 246 E. 31st st., Paterson
Yorke, Benjamin, 908 Main st., Paterson
Zick, Clara U., 60 Highland rd., Glen Rock
Zigarelli, Joseph F., 275 E. 18th st., Paterson
Zuckerman, David E., 568 Broadway, Paterson
Zuckerman, Louis, 568 Broadway, Paterson

ASSOCIATE MEMBERS

Abramo, Edward, 141 Glen av., Midland Park
Ainsworth, George E., 429 Piaget av., Clifton
Auerhan, Harold S., 142 Passaic av., Passaic
Carnecchia, Baldo M., 429 Piaget av., Clifton
Castiglia, Peter, 114 Valley rd., Clifton
Cohn, Perry, 234 Lexington av., Passaic
DeVries, Peter J., 180 Carroll st., Paterson
Effron, Samuel A., 666 Broadway, Paterson
Fonda, Donald A., 417 Getty av., Paterson
Guttmann, John S., 89 Mahar av., Clifton
Hennessy, John, Paterson General Hospital,Paters'n
Honig, Charles, 24 High st., Butler
Hurewitz, Benjamin, 0-95 Midland av., Fair Lawn
Johnson, Ernest E., 214 Lexington av., Passaic
Kennedy, Joseph F., 347 Valley rd., Clifton
Kolisch, Paul deR., 39 Waldron av., Glen Rock
Mahadeen, Onver, 51 Union av., Paterson
Miller, Howard B., 14-18 Chandler dr., Fair Lawn
Moog, Charles R., 208 Walton st., Ridgewood
Murphy, George E., 263 Franklin av., Ridgewood
Muster, William J., 525 E. Ridgewood av.,Ridgewood
Narrett, Sidney, 140 Passaic av., Passaic
Rosen, Albert P., 316 Kenneth av., Fair Lawn
Shpetner, Aaron F., 29-A Boulevard, E. Paterson
Tweddel, George K., Jr., 505 Park av., Paterson
Vogel, Helga S., 546 E. 29th st., Paterson

COURTESY MEMBERS

Goldfarb, Abraham, Rutherford
Kuhn, Richard E., Clifton
Larkey, Irving G., Newark
Lewin, Michael L., Paterson
Slaff, Florence, Passaic

EMERITUS MEMBERS

Becker, Leo V., Paterson
Bullen, Victor E., Paterson
Cogan, Henry, Daytona Beach, Florida
Crounse, David R., Passaic
Duncan, Owsley B., Paterson
Flitcroft, William, Waukesha, Wisc.
Golding, Harry N., Paterson
Maclay, Joseph A., Paterson
Mitchell, Charles R., Paterson
Murn, Charles J., Paterson
Ritter, John J., Plainfield, Mass.
Scribner, Charles H., Paterson
Vanderbeek, Andrew B., Paterson
Walton, Gordon G., Paterson
Yates, John S., Paterson

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

ACTIVE MEMBERS

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 140 W. Main st., Penns Grove
Cates, Haynes B., Shell rd., Penns Grove
Chesler, Maurice, 124 W. Broadway, Salem
Cox, J. Robert, 37 W. Main st., Penns Grove
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., 13 N. Broadway, Pennsville
Dunn, John S., 75 Market st., Salem
Evans, Edgar E., 12 Ziegler Tract, Penns Grove
Fleming, Charles L., 42 W. Main st., Penns Grove
Frazee, William H., Jr., Chambers W. H., Penns Gr.
Fullerton, Harry W., Jr., 86 Shell rd., Penns Grove
Gilpatrick, Charles E., 18 Spring st., Penns Grove
Green, David W., 69 Market st., Salem
Griffin, Joseph P., 79 Third st., Carneys Point
Hilliard, William T., 105 Market st., Salem
Hummel, Lee C., 109 W. Broadway, Salem
Hunt, John A., Chambers W. Hosp., Penns Grove
Jonas, August, 328 E. Broadway, Salem
Lipkin, Isadore, 157 W. Main st., Penns Grove
Mackes, Claude B., 48 N. Main st., Woodstown
Madara, John S., 31 Market st., Salem
Mason, Alvin S., 26 Olive st., Salem
Miller, William H., 7 Dickinson st., Woodstown
Neander, David G., 57 Chestnut st., Salem
Perry, Frank L., 39 East av., Woodstown
Quigley, Joseph A., 8 Ziegler Tract, Penns Grove
Seda-Morales, Ruben S., 31 East av., Woodstown
Silverman, R. Louis, 21 W. Main st., Penns Grove
Suter, Harry F., 49 W. Main st., Penns Grove
Thomas, Claudo W., 28 East av., Woodstown
Wetherhold, John M., 20 Ziegler Tract, Penns Grove
Wolfe, Humphrey D., 23 Spring st., Penns Grove
Zappala, John, 47 W. Main st., Penns Grove

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

ACTIVE MEMBERS

Abramson, Harry, 14 W. Young st., Somerville
Albrecht, William J., 46 Grove st., Somerville
Allegrante, Anthony J.,WashingtonValrd.,Martinsv'e
Ambrose, Robert R., 304 East High st., Bound Br'k
Barbour, George E., 118 W. High st., Somerville
Berliner, Harry M., Veterans Adm., Lyons
Blecher, Irving E., Veterans Administration, Lyons
Borow, Benjamin, 507 Church st., Bound Brook
Borow, Henry, 507 Church st., Bound Brook
Borow, Louis S., 507 Church st., Bound Brook
Borow, Maurice, 524 Church st., Bound Brook
Brittain, Elmore G., 15 W. Bridge st., Bound Brook
Case, Clarence E., Jr., 15 W. Bridge st., Somerville
Chase, Anthony V., 220 S. Main st., Manville
Cook, Caroline S., 27 E. Cliff st., Somerville
Cook, Homer E., 27 E. Cliff st., Somerville
Cooley, Justice H., II, 150 West High st., Somerville
Day, Hayward F., 92 Duer st., North Plainfield
Douglass, William C., 15 Olcott av., Bernardsville
Dresel, Irmgard, Mine Brook rd., Far Hills
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, Nicholas A., 68 Watchung av., N. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Fritts, Lewis C., 118 West End av., Somerville
Galgoczy, Julius, Box 473, Manville
Gentile, Ernest R., 125 Hamilton st., Bound Brook
Gewanter, Aaron P., Somerset Hosp., Somerville
Glass, George A., 282 E. Main st., Somerville
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Hartmann, Edmund M., 1414 Chetwynd av.,Plainfield
Hegeman, Runkle F., 161 W. High st., Somerville
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 417 Somerset st., Bound Brook
Husted, Samuel H., Main rd., Neshanic
Hyer, Godfrey S., 199 W. High st., Somerville
Jones, William F., 21 East High st., Somerville
Klompus, Irving, 301 E. High st., Bound Brook
Levy, Abram, 1401 Plainfield av., S. Plainfield
Liddell, Raymond N., 45 Grant av., Somerville
Loeb, William A., Veterans Administration, Lyons
Marcus, Bernard, 6 S. Clark av., Somerville
McKinley, C. Scott, Bakelite Corp., Bound Brook
Mintz, Julius, Sycamore av., North Plainfield
Misko, Albert, 117 Westervelt av., N. Plainfield
Patten, John, West Cliff st., Somerville
Pauly, Arthur N., 297 W. Summit st., Somerville
Pauncz, Arpad, Veterans Administration, Lyons
Pitman, Mason W. H., 17 Ross st., Somerville
Pogoloff, Samuel H., 269 N. First av., Manville
Powell, Matthew J. G., Main st., Bedminster
Reale, Nicholas P., Box 745, Manville
Renner, Clara C., Blawenburg
Rossi, Bartolomeo, 31 W. Main st., Bound Brook
Rossi, Gene, 148 W. Franklin st., Bound Brook
Russo, Dominic T., 51 E. Somerset st., Raritan
Sanford, Marcus E., 27 Ross st., Somerville
Sargent, Eva R., 121 Myrtle av., North Plainfield
Spaldo, John L., 32 Grove st., Somerville
Stolow, Alan A. J., 219 W. Summit st., Somerville
Tolomeo, Martin E., 5 E. High st., Bound Brook
Van Dyke, Laura V., 125 Hamilton st., Bound Brook
Van Horn, Abram L., 744 Broad st., Newark
Wallach, Bernard, 74 Watchung av., N. Plainfield
Wender, Harold, 103 Clinton st., So. Bound Brook
Wilson, Jon M., 125 Hamilton st., Bound Brook
Wolfsie, Jacob H., American Cyanamid Co., Linden
Young, James L., 68 Mountain av., Somerville

EMERITUS MEMBER

Craig, Henry A., Somerville

SUSSEX COUNTY (19)

Society organized August 22, 1829. Regular meetings in February, May, September and December at time, place and date designated by President and Secretary.

ACTIVE MEMBERS

Aitken, Herbert M., 1432 Morrison st.,Madison,Wisc.
Bergmann, Ewald H., 44 Bank st., Sussex
Boyd, William B., Jr., N. J. Zinc Co., Franklin
Braun, David C., 51 Trinity st., Newton
Burn, Victor E., 27 Trinity st., Newton
Caleca, Jack J., Andover
Cartisser, Joseph J., Stanhope
Catlett, George F., Newton
Coes, Harold V., Jr., R.F.D. 2, Sussex
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., 40 Bank st., Sussex
Ficker, Robert F., Ogdensburg
Hill, Dean F., Sussex
Johnson, George F., Branchville
Kirschner, Martin I., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
Lushear, Frank H., Branchville
McCall, Jesse, 9 Linwood av., Newton
McVeigh, Charles J. D., Main st., Stanhope
Morrison, Frederick H., 61 High st., Newton
Pellet, Thomas L., Hamburg
Piampiano, John, 27 Vernon av., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
Spencer, James H., Newton
Spurgeon, Chilton E., Newton
Spurgeon, Dorsett L., 19 Church st., Newton
Vermes, Leslie, 380 Rutherford av., Franklin
Weinstein, Robert A., 214 Spring st., Newton
Weiser, Edward H., 1 East Main st., Sussex

UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

Abel, Henri E., 339 Union av., Elizabeth
Abramson, Solomon, 1181 Jaques av., Rahway
Ackerman, Arthur F., 129 Summit av., Summit
Allen, Samuel L., 170 Union rd., Roselle Park
Anson, Leon J., 400 Center st., Garwood
Apfelbaum, Frederick M., 17 N. Tenth st.,Kenilworth
Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
Arthur, Frances H., 138 Westfield av., Elizabeth
Austin, Thomas R., 19 Holly st., Cranford
Axinn, Charles, 146 W. Gibbons st., Linden
Babbitt, Hugh M., Jr., 950 Park av., Plainfield
Balsbaugh, Edward F., 440 E. Broad st., Westfield
Barberio, A. Arthur, 1337 Orange av., Union
Baron, Leo E., 26 Prospect pl., North Plainfield
Baruch, Hilde, 202 Stiles st., Elizabeth
Baruch, Rudolf J., 202 Stiles st., Elizabeth
Bechet, Paul E., 1364 North av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Belle, Louis, 931 Jefferson av., Elizabeth
Belliveau, William J., 269 Morris av., Springfield
Bender, Dorothea A., 61 DeHart pl., Elizabeth
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
Berman, Leonard M., 382 Springfield av., Summit
Berman, Sol, 351 Rahway av., Elizabeth
Bernstein, Benedict J., Elizab'h-Carteret Hotel,Eliza.
Berry, C. Hartley, 129 Summit av., Summit
Biber, David, 900 Stuyvesant av., Union
Birrell, Russell G., 56 Church st., Toronto 1, Canada
Blatt, David, 737 Jefferson av., Elizabeth
Bloch, Harry, 613 N. Broad st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Rowland P., 30 Springfield av., Cranford
Boehm, Herbert, 610 Salem av., Elizabeth
Bolanowski, Kaslmier J., 145 Marshall st., Elizabeth
Bomar, Wirrion, 419 Spooner av., Plainfield
Booth, Walter S., 744 Rahway av., Elizabeth
Borak, Peter, Merck & Co., Rahway
Bourns, Edward G., 203 S. Euclid av., Westfield
Boyd, Robert P., 210 Martine av., S., Fanwood
Boyer, Paul K., 129 Summit av., Summit
Boyes, James G., Inman av., Plainfield
Braunwarth, Robert J., 555 S. Broad st., Elizabeth
Breslow, Alexander E., 930 Pierpont st., Rahway
Brethwaite, Samuel H., Jr., 129 Summit av., Summit
Brock, Howard F., 417 W. Broad st., Westfield
Brokaw, Christopher A., 615 N. Broad st., Elizabeth
Brown, Frank H., Jr., 327 Chestnut st., Roselle Park
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 501 First av., Elizabeth
Bruno, Anthony, 1092 Elizabeth av., Elizabeth
Buchanan, Robert W., 129 Summit av., Summit
Buffey, Walter H., McGuire VA Hosp., Richm'd,Va.
Burritt, Norman W., 382 Springfield av., Summit
Butenas, Joseph J., 300 First av., Elizabeth
Caldwell, Delma, Standard Oil Co., Linden
Callahan, Edward J., 124 St. Paul st., Westfield
Cannis, John P., 1019 Park av., Plainfield
Cantini, Raphael S., 727 Watchung av., Plainfield
Card, Charles F., 144 W. Milton av., Rahway
Cardinale, Pasquale F., 1405 North av., Elizabeth
Carlisle, J. Mallory, 550 Hillcrest av., Westfield
Caro, Eugene P., 926 Wood av., N., Linden
Carpenter, Cedric C., 97 Hobart av., Summit
Carroll, Bruce J., 469 W. Front st., Plainfield
Carsley, Sidney H., 19 Holly st., Cranford
Casey, Robert B., 51 W. Milton av., Rahway
Casilli, Arturo R., 618 Newark av., Elizabeth
Castaldo, Neil, 103 Lincoln av., E., Cranford
Chaiken, Louis H., P. O. Box 51, Elizabeth
Chapman, Otis P., 400 Westminster av., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Chodosh, Maurice A., 606 Roosevelt av., Carteret
Coe, Edward M., 217 Holly st., Cranford
Cohen, Harry X., 1267 Stuyvesant av., Union
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
Colley, Arthur T., 916 Park av., Plainfield
Comunale, Anthony R., 1709 Irving st., Rahway
Connolly, Joseph A., 124 Firth st., S. Plainfield
Conover, Elizabeth, 129 Summit av., Summit
Constad, Arnold N., 944 Stuyvesant av., Union
Conway, James V., 428 Elmora av., Elizabeth
Coplin, George J., 528 E. Jersey st., Elizabeth
Corbusier, Harold D., 612 Park av., Plainfield
Cox, William T. R., 345 S. Broad st., Elizabeth
Crabtree, Loren H., 505 Jersey av., Elizabeth
Crane, Norman T., 1025 Sleepy Hollow lane,Plainf'd
Cronin, Francis J., 730 South st., Elizabeth
Dalberg, Walter, 500 Cherry st., Elizabeth
Darlington, Charles G., 802 Belvidere av., Plainfield
Davidson, E. Norwell, 102 East Elm st., Linden
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. Seventh st., Plainfield
Day, Willis B., 407 E. Seventh st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., RosellePark
Decker, Charles T., 275 Orchard st., Westfield
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth
Demarest, Gerald B., 505 E. Broad st., Westfield
Demy, Nicholas G., 912 Prospect av., Plainfield
Dengler, Henry P., 260 Morris av., Springfield
Denholm, John S., 1048 Coolidge rd., Elizabeth
Deutsch, Nathan S., 223 E. Fifth st., Plainfield
Diamond, J. George, 512 W. Front st., Plainfield
Diefendorf, Herbert W., 129 Summit av., Summit
Dinneen, James B., 503 Park av., Plainfield
Doggett, E. Hugh, 805 Park av., Plainfield
Doherty, William, 830 N. Wood av., Linden
Dolsky, Irving, 509 N. Wood av., Linden
Donauer, Robert M., 34 Bedford rd., Summit
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Dudley, Henry G., 222 Sylvania pl., Westfield
Dunn, H. Irving, 610 Salem av., Elizabeth
Dupuy, Jean G., 850 Jersey av., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
Dwoyer, Leon C., 420 N. Wood av., Linden
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Max, 721 N. Broad st., Elizabeth
Esty, Geoffrey W., 629 E. Broad st., Westfield
Falcone, Albert M., 502 E. Broad st., Westfield
Ferenchak, Ralph, 219 Martine av., N., Fanwood
Fidler, Jay W., Jr., 1441 Hazelwood ter., Plainfield
Fiedler, Michael J., 2368 S. W. 4th st., Miami, Fla.
Figliolino, Francis, 272 W. Milton av., Rahway
Fink, Stanley J., 221 Chestnut st., Roselle
Fitch, Thomas S. P., 916 Park av., Plainfield
Folsome, Clair E., 1075 Central av., Plainfield
Forsberg, Roy T., 110 W. Fifth av., Roselle
Foster, Frank L., 320 Springfield av., Cranford
Frankel, Theodore H., 600 Crescent av., Plainfield
Franklin, Joseph E., 191 North av., Hillside
Franklin, Lewis J., 149 Jean ter., Union
Freeman, Ray M., 2011 St. Georges av., Rahway
Friedlander, Erwin W., 213 Westfield av., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Gadomski, Casimir F., 331 S. Broad st., Elizabeth

Gallaway, George E., 163 W. Milton av., Rahway
Gannon, Joseph M., 149 Crescent av., Plainfield
Geary, Paul, 909 Park av., Plainfield
Geib, Margaret E., 1277 Clinton pl., Elizabeth
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Giacona, Joseph, 221 Lincoln av., Union
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av., W., Cranford
Gittelman, Morton, 879 Newark av., Elizabeth
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glass, Harry L., 1009 Park av., Plainfield
Goldberg, Harry C., 7 Watchung av., Plainfield
Golden, William M., 236 W. Milton av., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edward J., 420 Jersey av., Elizabeth
Goodspeed, William K., Oakwood rd., Watchung
Gorman, Rosemary, 811 N. Broad st., Elizabeth
Grant, William E., 1370 Morris av., Union
Greenberg, Max, 29 W. Henry st., Linden
Griesemer, Laurence C., 515 Locust st., Roselle
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizab'th
Griswold, Merton L., Jr., 947 Park av., Plainfield
Hackett, Daniel C., 132 S. Euclid av., Westfield
Hall, Ralph A., 547 E. Broad st., Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hamley, John J., 153 Second st., Elizabeth
Hanrahan, James, 678 N. Broad st., Elizabeth
Hansen, Harry, 1006 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Harris, Sidney, 301 W. Fifth av., Roselle
Hely, Charles J.,Jr., 564 Summit av., Westfield
Heminway, Norman L.,106 Short Hills av.,Sh'rt Hills
Henderson, Worth W., 469 W. Front st., Plainfield
Herrington, Lee R., 643 E. Broad st., Westfield
Hill, Clarence T., 116 E. Hazelwood av., Rahway
Hipple, Percy L., 118 E. Fifth av., Roselle
Hirsch, Albert, 1554 Irving st., Rahway
Hirsch, Lucien, 160 E. Seventh st., Plainfield
Hnat, Frederick, 565 Newark av., Elizabeth
Hoch, Samuel M., 240 Hillside rd., Elizabeth
Hoffman, Charles A., 302 E. Seventh st., Plainfield
Hoffman, Harry, 805 Park av., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Holtzman, Michael, 734 N. Broad st., Elizabeth
Hopper, Guy R., 147 Elmer st., Westfield
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hutton, Frederick T., 717 Watchung av., Plainfield
Imbleau, Joseph E. L., 2106 Morris av., Unionville
Jacobs, Alan L., 1243 Stuyvesant av., Union
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 6 Hillside rd., Elizabeth
Jones, Lewis H., 139 E. Grant av., Roselle Park
Judd, Joseph, Jr., 300 Westfield av., Elizabeth
Kandra, Paul H., 153 Mountain av., Westfield
Kaplan, Samuel D., 615 N. Broad st., Elizabeth
Kapp, Carl G., 440 Westminster av., Elizabeth
Karel, Jack R., 407 Jersey av., Elizabeth
Karnay, Francis, 416 Center st., Garwood
Karshmer, Ernest E., 420 Wood av., N., Linden
Katz, Theodore, 540 S. Wood av., Linden
Kaycoff, Aaron J., 628 Wood av., N., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Keil, Sigmund S., 1118 St. George av., E., Linden
Kemeny, George, 39 Third st., Elizabeth
Kennedy, John N., 831 Madison av., Plainfield
Kent, Louis R., 1974 St. Georges av., Rahway
Kertis, Eugene R., 272 E. Second av., Roselle
Kidd, Ruth W., 1199 Morris av., Union
Klapper, Lester L., 967 Park av., Plainfield
Kline, Nathan S., 41 Beechwood rd., Summit
Kloby, John J., 562 Bayway, Elizabeth
Knauer, George, 930 Elizabeth av., Elizabeth
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 224 E. Jersey st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Kyle, Ernest I., 205 W. Ninth st., Plainfield
Labow, Joseph J., 757 N. Broad st., Elizabeth
Lance, Elton W., 125 W. Milton av., Rahway
Lang, Louis, 947 E. Jersey st., Elizabeth
Lang, Richard W., 1003 Park av., Plainfield
Langston, Junius T., 521 E. Second st., Plainfield
Larrabee, Callie H., 10 Irving pl., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Leone, Peter P., 27 Princeton rd., Elizabeth
Lepree, Joseph A., 371 Morris av., Elizabeth
Lerman, Frederick, 1024 E. Jersey st., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lerman, Samuel, 116 Brightside av., Pikesville, Md.
Levitsky, Edward, 767 E. Third av., Roselle
Lewis, Alexander, 113 E. Milton av., Rahway
Lewis, Robert L., Jr., 636 Westminster av., Elizabeth
Lieberman, David P., 597 Westminster av., Elizab'h
Lieberman, Milton L., 101 Pershing av., Roselle Pk.
Lilien, Milton M., 152 Clark st., Hillside
Lipson, Stanley, 717 N. Wood av., Linden
Livengood, Horace R., 587 Westminster av., Elizab'h
Livingston, Sydney R., 650 W. Seventh st., Plainfield
Llull, Gabriel J., 266 Morris av., Springfield
Loizeaux, Edward C., 320 E. 7th st., Plainfield
Loizeaux, Theodore, 212 E. Seventh st., Plainfield
Lomax, Charles L., 417 W. Broad st., Westfield
Longbothum, George M., 733 Watchung av., Plainfi'd
Losada, Camella A., P. O. Box 194, Central Val.,N.Y.
Lowell, Milton E., 434 Summit av., Westfield
Lowenstein, Ernest C., 259 W. Milton av., Rahway
Lufburrow, Charles B., 441 W. Front st., Plainfield
Lyerly, James M., 815 Park av., Plainfield
Lyght, Charles E., Merck & Co., Rahway
Lynch, Edward T., 748 Livingston rd., Elizabeth
MacDonald, Edward O., 719 Locust st., Roselle Park
Mackler, Harry S., 752 N. Broad st., Elizabeth
Maggio, Ross J., 206 Park av., Westfield
Malatesta, Charles S., 1203 Martine av., Plainfield
Mallison, Herbert, 819 Park av., Plainfield
Marone, Carmine R., 752 Newark av., Elizabeth
Maroney, James H., 129 Summit av., Summit
Martin, William E., 110 Claremont pl., Cranford
Marts, George H., 956 Park av., Plainfield
Mast, Joseph E., 1270 Magio av., Elizabeth
Mastroianni, Frank M., 634 Sherman av., Roselle Pk.
Maurer, Martha E., 153 Mountain av., Westfield
McAlpine, Paul, 129 Summit av., Summit
McCallion, Wm. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1439 Maple av., Hillside
McGinn, William J., 1913 Westfield av., ScotchPlains
Mechanik, Harvey K., 121 E. Seventh st., Plainfield
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 820 Chestnut st., Roselle
Mensch, Harvey G., 1117 Mary st., Elizabeth
Merlo, Francis A., 210 Murray st., Elizabeth
Merlo, Francis V., 33 Prince st., Elizabeth
Miller, George M., 288 Elm av., Rahway
Miller, Robert M., 36 Woodland av., Summit
Milliser, Estelle T., 126 N. Euclid av., Westfield
Mohr, Frank L., 560 Morris av., Summit
Moon, Dabney vonK., 706 Park av., Plainfield

Morris, Karl E., 648 E. Broad st., Westfield
Morris, Nathan, 607 E. Second st., Plainfield
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Naidorff, Saul A., 421 W. Seventh st., Plainfield
Nelson, Francis B., 275 Orchard st., Westfield
Neumann, Alfred, 432 Washington av., Linden
Nevins, Thomas F., Jr., 105 Linden av., Westfield
Nevius, John K., Jr., 1165 Park av., Plainfield
Newbury, Graham C., 234 Summit av., Summit
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth
Nussbaum, Joseph, 321 Elmora av., Elizabeth
O'Brian, E. Raymond, 831-B E. Front st., Plainfield
O'Brien, Edwin J., Jr., 733 Watchung av., Plainfield
Olson, John A., 19 Holly st., Cranford
Orton, Foster, 196 Elm av., Rahway
Orton, Stuart, 196 Elm av., Rahway
Owen, Philip, 973 Salem rd., Union
Palin, George, 27A Wavecrest av., Winfield
Palmer, Harris H., 6 Willow Grove Pkwy., Westfield
Palumbo, Vincent A., 22nd & Boulevard, Kenilworth
Pearl, Sydney S., 837 Park av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Pierson, Howard W., Jr., 926 Park av., Plainfield
Pogue, Elbert H., 168 Madison av., Elizabeth
Polk, Charles C., 114 E. Seventh av., Roselle
Pollack, Louis, 2052 Morris av., Union
Potekhen, George P., 1232 Park av., Plainfield
Prazak, Beatrice, 1024 E. Jersey St., Elizabeth
Price, Kasper J., 715 Westfield av., Elizabeth
Puller, Hyman, 217 Chestnut st., Roselle
Read, Jessie D., 519 Lenox av., Westfield
Reale, Frank P., 427 W. Seventh st., Plainfield
Reich, Jerome J., 1500 N. Broad st., Hillside
Reilly, David F., 44 Prince st., Elizabeth
Reilly, John, Jr., 222 Elizabeth av., Elizabeth
Relyea, George M., 129 Summit av., Summit
Repta, Stephen, 2165 Morris av., Union
Roberts, Dudley A., 124 St. Paul st., Westfield
Robertson, Grace M., 515 W. Seventh st., Plainfield
Rogers, Herman C., Bonnie Burn Sana., Scotch Pls.
Rosenblatt, Max B., 150 Westfield av., Elizabeth
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Rowen, Manuel J., 133 W. Jersey st., Elizabeth
Rumsey, Wm. L., Jr., 1336 North av., Elizabeth
Runnells, John E., Bonnie Burn San., Scotch Plains
Sadoff, Joseph, 504 Westminster av., Elizabeth
Sagi, Ellen I., 376 Elmora av., Elizabeth
Salvati, Leo H., 1250 Prospect st., Westfield
Satulsky, Emanuel M., 737 N. Broad st., Elizabeth
Sauerbrun, Bertram J. L., 681 Newark av., Elizabeth
Scalessa, Mario F. T., 209 Ashland rd., Summit
Schenk, Joseph R., 1177 Park av., Plainfield
Schiller, Rosa O., 523 Westfield av., Elizabeth
Schillinger, Raphael, 858 Summit av., Westfield
Schlein, David, 812 N. Wood av., Linden
Schwartz, Samuel H., 916 Park av., Plainfield
Scott, Kenneth H., Jr., 734 Park av., Plainfield
Seidmon, Edward E., 221 W. Seventh st., Plainfield
Sena, Dominic R., Univ. Hosp., Coral Gables, Fla.
Senerchia, Fred F., Jr., 457 Union av., Elizabeth
Seybold, Arthur D., 1080 Rahway rd., Plainfield
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
Shapiro, Max, 414 Elizabeth av., Elizabeth
Sheedy, John J., 121 E. Seventh st., Plainfield
Shepard, Adele C., 818 Summer st., Elizabeth
Shepard, Morse A., 17 N. 18th st., Kenilworth
Shulman, Philip, 308 Chestnut st., Roselle
Silverman, Theodore M., 105 Elmora av., Elizabeth
Simonds, William R., 245 E. Front st., Plainfield
Sims, Richard V., Jr., 31 Morris av., Summit
Singer, Bella, 640 Wyoming av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Smith, J. James, 818 N. Broad st., Elizabeth
Snyder, Howard P., 610 Salem av., Elizabeth
Sordill, Anthony, 1114 Grandview av., Westfield
Speer, Charles A., 19 Holly st., Cranford
Spence, Harold G., 26 Badeau av., Summit
Spirito, Michael W., 219 S. Broad st., Elizabeth
Spivack, David, 315 W. Jersey st., Elizabeth
Spivack, Seymour E., 405 Chestnut st., Roselle
Staub, E. Milton, 505 E. Broad st., Westfield
Staub, Wilfred A., 531 E. Broad st., Westfield
Steele, Stephen, 10 West Gibbons st., Linden
Steffens, Charles T., 612 Park av., Plainfield
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., 640 Wyoming av., Elizabeth
Stein, Isadore, 817 N. Broad st., Elizabeth
Steinberg, Werner, 35 Gesner st., Linden
Stephenson, Gordon A., 145 Summit av., Summit
Stevenson, G. McKay, 129 Summit av., Summit
Strelinger, Alexander, 650 N. Broad st., Elizabeth
Strom, Abraham, 410 W. Seventh st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Stybel, Joseph, 507 Park av., Plainfield
Suffness, Gustave, 970 Park av., Elizabeth
Sweeney, Ralph E., 406 Elmora av., Elizabeth
Taranto, Michael, 13 E. Gibbons st., Linden
Tator, Arthur E., 57 DeForest av., Summit
Thompson, Minturn R., 530 W. Broad st., Westfield
Thompson-Bohne, Mildred H., 62 Elm st., Summit
Tidaback, Austin J., 981 Townley av., Townley
Tolor, Stanley, 405 Westminster av., Elizabeth
Tomlinson, Rolland D., 502 E. Broad st., Westfield
Townsend, Leslie M., 420 Chestnut st., Roselle Park
Trano, Giovanni, 941 E. Jersey st., Elizabeth
Triarsi, Anthony J., 702 Third av., Elizabeth
Tyndall, Alice E., 263 Walnut st., Westfield
Tyndall, Martha W., 263 Walnut st., Westfield
VanEerde, Albert, 911 N. Wood av., Linden
Vinciguerra, Michael, 604 Westminster av., Elizabeth
Vitale, Dominic V., 749 N. Broad st., Elizabeth
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Vogel, Nathan F., 297 Morris av., Springfield
Wacker, William F., 1224 Salem av., Hillside
Wagner, Richard, 915 Springfield av., N. Providence
Walsh, Ronald J., 338 S. Broad st., Elizabeth
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Webb, Eleanor A., 887 Springfield av., Summit
Wegryn, Louis S., 257 Elizabeth av., Elizabeth
Weigel, Edgar W., 210 W. Jersey st., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Weissberg, William W., 800 N. Broad st., Elizabeth
Weissman, Meyer T., 1137 E. Jersey st., Elizabeth
Weitz, Abraham, 2512 S. Chester av., Bakersfield, Cal.
Weltchek, Herbert, 439 Jersey av., Elizabeth
Whitken, Albert I., 1056 North av., Elizabeth
Widdowson, William W., Bell Tele. Lab., Mur. Hill
Willetts, Arthur T., 129 Summit av., Summit
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, Leonard D., 726 Watchung av., Plainfield
Williams, Manley C., 735 E. Milton av., Rahway
Wolff, Jerome M., 935 Park av., Plainfield
Wolgin, Philip L., 445 Elmora av., Elizabeth
Wuester, William O., 238 Exeter way, Hillside
Yellin, Charles H., 915 Jersey av., Elizabeth
Yood, Harold S., 401 Grant av., Plainfield
Yorke, Edward T., 1717 N. Wood av., Linden
Young, Franklin C., 120 Summit av., Summit
Young, Ralph A., 842 N. Wood av., Linden

Yuckman, Robert O., 701 Madison av., Elizabeth
Zeitlin, Herman H., 943 N. Wood av., Linden
Zirpolo, Gene A. V., 1128 Bryant st., Rahway

EMERITUS MEMBERS

Guidi, Guido M., Elizabeth
Hughes, Frederic J., San Mateo, Cal.
Krans, Edward S., Plainfield
Lawrence, William H., DeLand, Fla.
Orton, George L., Rahway
Tidaback, John D., Summit
Wade, Simon F., Milford, Pa.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

ACTIVE MEMBERS

Baldauf, Herman, Jr., 210 Greenwich st., Belvidere
Bartolini, Frank, 122 Belvidere av., Washington
Bertland, Alexander D., 142 Belvidere av.,Wash'gton
Bloom, G. Homer, 674 Hillcrest Blvd., Phillipsburg
Boquist, Walter A., 380 Hudson st., Phillipsburg
Bossard, Harry B., R. D. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasefield, Edgar N., 218 Chambers st., Phillipsburg
Buchanan, Ralph M. L., 8 Market st., Phillipsburg
Cooper, Ray C., 173 E. Washington av., Washington
Drake, Paul F., 85 Summit av., Phillipsburg
Genninger, Lewis E., 95 S. Main st., Phillipsburg
Hampton, John E., 122 Belvidere av., Washington
Humbert, Joseph C., Jr., Stewartsville
Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., 137 Belvidere av., Washington
Marlett, Neumann C., 230 Greenwich st., Belvidere
Martin, Francis E., Lake rd.,Box 83, Morrist'n,R.D.1
McDonald, John, Jr., 322 Fifth st., Belvidere
Michell, George E., 221 High st., Hackettstown
Miller, Charles E., 228 Main st., Hackettstown
Potter, Charles W., 184 Belvidere av., Washington
Ringe, Charles L., Jr., Blair pl., Blairstown
Sheffield, Doreen R. C., R. D. 1, Oxford
Shevitz, David M., 212 Grand av., Hackettstown
Smith, Herman, 306 Bates st., Phillipsburg
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Stone, Russell B., 56 Summit av., Phillipsburg
Varney, William H., 122 Belvidere av., Washington
West, Guernsey F., Barrymore st., Phillipsburg
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zdanowicz, Stefan J., 117 Grand av., Hackettstown
Zuck, Arthur C., 22 Broad st., Washington

COURTESY MEMBERS

Friedman, Leon, Easton, Pa.
Skinner, William, Easton, Pa.

EMERITUS MEMBERS

Gordon, Frank S., Blairstown
Shimer, Floyd A., Phillipsburg
West, Heston R., Phillipsburg

An Alphabetical List of the Members of The Medical Society of New Jersey

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

COMPILED MARCH 1, 1950

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ACTIVE MEMBERS

Abarbanel, Milton G., 301 Rochelle av., RochelleP.(2)
Abbott, Charles C., 32 Main st., Lodi (2)
Abel, Arthur R., Orange Mem. Hosp., Orange (7)
Abel, Henri E., 339 Union av., Elizabeth (20)
Abers, Bernard D., 565 Summit av., Jersey City (9)
Abey, William J. H., 65 S. Main st., Pennington (11)
Abramo, Anthony E., 141 Glen av., Midland Pk. (16)
Abrams, Abram B., 299 Clinton av., Newark (7)
Abrams, Henry, 195 Nassau st., Princeton (11)
Abramson, Harry, 14 W. Young st., Somerville (18)
Abramson, Solomon, 1181 Jaques av., Rahway (20)
Ackerhalt, Martin J., 408 Clifton av., Clifton (16)
Ackerman, Arthur F., 129 Summit av., Summit (20)
Ackley, David B., 21 N. Clinton av., Trenton (11)
Adelman, Benjamin B., 186 Clinton av., Newark (7)
Adler, Fritz F., 777 Market st., Paterson (16)
Adler, Howard E., 103 Livingston av., N.Br'sw'k(12)
Adler, Lydia, 103 Livingston av., N. Brunswick (12)
Adler, Samuel, 229 Broad st., Red Bank (13)
Africano, Julius V., 43 Columbia ter., Weehawken(9)
Africano, Scipio H., 526 15th st., Union City (9)
Agayoff, John D., 127 S. Wash'gton av., Bergenf'd(2)
Agnew, Hobart M., 17 Plymouth st., Montclair (7)
Agolia, Michael W., 2201 Palisade av., Union City(9)
Aitken, Frank J., 62 N. Pearl st., Bridgeton (6)
Aitken, Herbert M., 1432 Morrison st.,Madis'n,W.(19)
Albano, Edwin H., 144 Harrison st., East Orange (7)
Albano, Frank J., 535 N. Seventh st., Newark (7)
Albano, Joseph, 535 N. Seventh st., Newark (7)
Albert, Perry, 2780 S. Broad st., Trenton (11)
Albini, Mario, 204 Fifth st., Hoboken (9)
Albrecht, William J., 46 Grove st., Somerville (18)
Albright, Louis F., 118 Madison av., Spring Lake(13)
Alcamo, John H., 321 S. Ninth st., Newark (7)
Alcaro, Joseph A., 2 Perry st., Morristown (14)
Alessi, Alfred A., 174 Merrison st., Teaneck (2)
Alexander, John W., 308 Main st., Orange (7)
Alexander, Samuel, 108 Pascack rd., Park Ridge (2)
Alexander, Stewart F., 108 Pascack rd.,Park R'ge(2)
Alexander, Walter G., 48 Webster pl., Orange (7)
Allan, James S., 144 Harrison st., East Orange (7)
Allar, Ellis H., 115 St. Charles pl., Atlantic City (1)
Allegrante, Anthony J., Wash'gt'nV.rd.,Mart'sv'e(18)
Allen, Arthur A., 365 Park av., Paterson (16)
Allen, Chester B., Jr., 42 Gordonhurst av., M'tcl'r(7)
Allen, Edwin J., 269 Carroll st., Paterson (16)
Allen, James M., 585 Main st., Passaic (16)
Allen, Raymond N., 144 Harrison st., E. Orange (7)
Allen, Samuel L.. 170 Union rd., Roselle Park (20)
Allman, David B., 104 St. Charles pl., Atl. City (1)
Alonzo, Gerard J., 477 Stuyvesant av.,Lyndhurst(16)
Alpert, Edward, 661 Jersey av., Jersey City (9)
Alpert, Sidney, 321 Second st., Lakewood (15)
Alpren, Bernard F., 17 Church st., Paterson (16)
Alterbaum, George, 25 Park av., Caldwell (7)
Altman, Charles D., 116 Fairmount av., Newark(7)
Altschul, Frank J., 177 Garfield av., L. Branch (13)
Amato, Charles P., 500 Cooper st., Camden (4)
Amato, John R., 1134 Broad st., Newark (7)
Ambrose, Anthony, 15 Washington st., Newark (7)
Ambrose, Francis, 377 Park av., Paterson (16)
Ambrose, Robert R., 304 E. High st., B. Brook (18)
Amdur, Louis A., 2540 Boulevard, Jersey City (9)
Amster, Milton W., 439 Meeker st., South Orange (7)
Anastor, Herbert C., 641 Wood st., Vineland (6)
Anderson, Ethelyn J., 195 Euclid av.,Ridge'f'd Pk.(2)
Anderson, John F., 195 College av., N. Brunsw'k(12)
Anderson, Merton B., 727 Walnut st., Camden (4)
Anderson, Reuben M., 15 Anderson st., Hack'ns'k(2)
Anderson, Robert C., 686 Mt. Prospect av., New'k(7)
Anderson, William A., 1310 Broad st., Bloomfield(7)
Andrews, Albert G. K., P.O. Box 743, Passaic (16)
Andrews, Clarence L., 1616 Pacific av., Atl. City (1)
Andrick, Eugene A., 99 Sheridan av., Hohokus (2)
Andrus, David L., 805 Cooper st., Camden (4)
Angelillo, Marc C., 177 Elwood av., Newark (7)
Angelo, Joseph A., Bank bldg., Secaucus (9)
Angioletti, Louis V., 1617 Palisade av., Fort Lee (2)
Annitto, John E., 170 Belmont av., Jersey City (9)
Anrig, Grace E., 613 Summit av., Union City (9)
Anson, Leon J., 400 Center st., Garwood (20)
Antonius, Nicholas A., 27 W. Market st., Newark (7)
Antopol, William A., 24 Stengel av., Newark (7)
Anuario, Charles B., 365 S. Centre st., Orange (7)
Apfelbaum, Fred'r'k M.,17 N.Tenth st.,Kenilw'th(20)
Apple, Stanley B., 1520 Brunswick av., Trenton (11)
Applebaum, Irving L., 31 Lincoln Park, Newark (7)
Applestein, Robert, 375 W. State st., Trenton (11)
Appleton, Ralph, Lincoln av., Point Pleasant (15)
Appold, George D., 60 E. Church st., Bergenfield (2)
Apter, Abraham H., 45 Church st., Paterson (16)
Arbeit, Sidney R., 56 Gifford av., Jersey City (9)
Aria, Charles J., 1818 Boulevard, Jersey City (9)
Aria, Michael H., 31 Glenwood av., Jersey City (9)
Armstrong, Lorrimer B., 121 S. Euclid av., W'tf'd(20)
Aronis, Harry R., 935 W. State st., Trenton (11)
Aronoff, Herman L., 225 Claremont av., Jer. City (9)
Aronowitz, Harry T., 923 Avenue C., Bayonne (9)
Arons, Harry, 31 Lincoln Park, Newark (7)
Aronsohn, Charles M., 459 Park av., Paterson (16)
Artaserse, George V., 185 Bergen av., Jersey City (9)
Arthur, Frances H., 138 Westfield av., Elizabeth (20)

Asbell, Nathan, 326 Cooper st., Camden (4)
Ash, Arthur F., 710 Boulevard, E., Weehawken (9)
Ash, Frank W., 180 Carroll st., Paterson (16)
Ash, Samuel, 866 S. 13th st., Newark (7)
Aszody, Paul, 340 Waverly av., Newark (7)
Athey, Kenneth L., 3616 Westfield av., Camden (4)
Atwood, Edward A., 360 Park av., Paterson (16)
Audi, Eugene H., 466 S. Maple av., Glen Rock (2)
Auerbach, Friedrich, 490 Stuyvesant av., Irv'gt'n(7)
August, Jacob, 149 Rhode Island av., E. Orange (7)
Auriemma, Michele, 421 Adams st., Hoboken (9)
Austin, Henry J., 96 Bellevue av., Trenton (11)
Austin, Thomas R., 19 Holly st., Cranford (20)
Autorino, Ralph R., 10 Harrison av., Montclair (7)
Averbach, Jacob, 435 Clifton av., Clifton (16)
Avery, Philip S., Woodland ter., Bound Brook (12)
Axilrod, Maurice H., 2620 Pacific av., Atl. City (1)
Axinn, Charles, 146 W. Gibbons st., Linden (20)
Ayars, Paul K., Main & Temperance sts.,P.Norris(6)
Aymar, Dorothy, 608 Fourth st., Union City (9)

ASSOCIATE MEMBERS

Abramo, Edward, 141 Glen av., Midland Park (16)
Ainsworth, George E., 429 Piaget av., Clifton (16)
Areson, Robert H., 153 Bellevue av.,Up.Montclair(7)
Auerhan, Harold S., 142 Passaic av., Passaic (16)

B

ACTIVE MEMBERS

Babbitt, Hugh M., Jr., 950 Park av., Plainfield (20)
Bachmann, William, 87 Hillcrest ter., E. Orange (7)
Bacon, Mary, 278 E. Commerce st., Bridgeton (6)
Bacote, Ernest F., 680 High st., Newark (7)
Baer, Irving, 65 Branch av., Red Bank (13)
Baeseman, R. Winfield, 112 Main st., Allenh'st (13)
Bahnson, Conrad M., 170 Bowers st., Jersey City (9)
Baime, Jules E., 72 Prospect st., East Orange (7)
Baiocchi, Pascal J., 203 Hunterdon st., Newark (7)
Baker, Augustus L., 389 W. Blackwell st., Dover(14)
Baker, Augustus L., Jr., 389 W. Bl'kw'l st.,Dover(14)
Baker, Banks S., 618 Benson st., Camden (4)
Baker, Elsworth F., 58 Reckless pl., Red Bank (13)
Baker, Hugh W., Eighth & Elmer sts., Vineland (6)
Baker, Maclyn F., 987 Sanford av., Irvington (7)
Baker, Maurice E., 1149 Kaighn av., Camden (4)
Baker, Philip W., High Bridge (10)
Baldauf, Herman, Jr., 210 Greenwich st.,Belvid'e(21)
Baldini, Charles F., Jr., 513 15th st., Union City (9)
Baldini, Howard E., 513 15th st., Union City (9)
Baldwin, Charles H., 2829 Atlantic av., Atl. City (1)
Baldwin, John F., 58 Ayers ct., W. Englewood (2)
Balis, Samuel B., 67 Baldwin av., Newark (7)
Balles, Edward S., 392 Park av., Paterson (16)
Balogh, William A., 315 Dunellen av., Dunellen (12)
Balsamo, Anthony J., 16 Enos pl., Jersey City (9)
Balsamo, Joseph J., 224 So. Eighth st., Newark (7)
Balsbaugh, Edward F., 440 E. Broad st., Westf'd(20)
Balson, Zachary D. B., 49 Osborne ter., Newark (7)
Balze, Henry R., 218 Broad av., Leonia (2)
Bambara, Aurelius J., 6 N. Main st., Flemington(10)
Banta, Edward E., 64 Peters pl., Red Bank (13)
Banta, Raymond E., 288 Orchard pl., Ridgewood (2)
Bar, Samuel, Englishtown (13)
Barb, Kirk B., 1303 Princess av., Camden (4)
Barbano, Alfred J., 225 Hale st., New Brunswick(12)
Barbarito, William N., 135 Bentley av., Jer. City (9)
Barbash, Roslyn H. W., 835 Red rd., Teaneck (2)
Barbella, Joseph D., 498 N. 13th st., Newark (7)
Barberio, A. Arthur, 1337 Orange av., Union (20)
Barbour, George E., 118 W. High st., Somerville (18)
Bardfeld, Benjamin B., 1080 E. Landis av.,Vinel'd(6)
Barkhorn, Charles W., 223 Roseville av., Newark (7)
Barlow, Bernard G.,Wright Aero.Corp.,Wood-R'ge(2)
Barlow. Frank A.,Veterans Hosp.,Bay Pines,Fla.(16)
Barlow, G. Barton, 157 Engle st., Englewood (2)
Barlow, John D., 232 Stockton st., Hightstown (11)
Barnard, Frank G., 79 Hawthorne pl., Montclair (7)
Barnes, William J., 155 Engle st., Englewood (2)
Barnett, Jack, 388 12th av., Paterson (16)
Barnett, Lester A., 300 Deal Lake dr., Asbury P.(13)
Barnett, Robert W., 601 Grand av., Asbury Park(13)
Barnhardt, Russell A., 10 Deerfield rd., Parlin (12)
Barnshaw, Harold D., 524 Cooper st., Camden (4)
Barolsky, Benjamin, 452 15th av., Paterson (16)
Baron, Herbert A., 150 Terrace av., Hasbr'k Hts.(2)
Baron, Leo E., 26 Prospect pl., N. Plainfield (20)
Barone, Leo J., 392 Van Houten st., Paterson (16)
Barr, Joseph, 975 Madison av., Paterson (16)
Barrett, James, 252 N. Arlington av., E. Orange (7)
Barrett, John E., 220 Woodside av., Newark (7)
Barrett, Joseph F., 230 Parker av., Maplewood (7)
Barroway, James N., 2714 Westfield av., Camden (4)
Barrows, Victor I., 106 W. 11th st., N. Wildwood (5)
Barry, R. Grant, 908 W. State st., Trenton (11)
Bartolini, Frank, 122 Belvidere av., Washington(21)
Baruch, Hilde, 202 Stiles st., Elizabeth (20)
Baruch, Rudolf J., 202 Stiles st., Elizabeth (20)
Basralian, Joseph B., 333 Wash'gt'n pl.,Hasb'kHts(2)
Bass, Morris, 414 Chancellor av., Newark (7)
Bass, Rose D., 54 Lyons av., Newark (7)
Bassett, Lavern C., 320 New Market rd., Dunell'n(12)
Bassett, Norman H., 1616 Pacific av., Atlantic C.(1)
Battaglia, Albert J., 62 Hunter st., Woodbury (8)
Battin, Richard P., 149 Prospect st., Passaic (16)
Bauer, John T., 312 E. Second st., Moorestown (3)
Baum, Felix, 406 Centre st., South Orange (7)
Baum, Lewis F., 406 Centre st., South Orange (7)
Baum, Otto S., 406 Centre st., South Orange (7)
Baum, Samuel, 10 Osborne ter., Newark (7)
Bauman, Everett O., 862 S. 13th st., Newark (7)
Bauman, Rush C., 92 High st., Nutley (7)
Baxt, Sidney J., 544 21st av., Paterson (16)
Bayer, Eric C., 307 E. Madison av., Dumont (2)
Bayer, Harold J., 1616 Pacific av., Atlantic City (1)
Bayne, Joseph K., Army (11)
Bealrsto, Everett B., 224 W. State st., Trenton (11)
Beakes, Charles H. C., 155 Engle st., Englewood (2)
Beall, William T., Salem Pike, Clarksboro (8)
Beard, James R., Jr., Taff dr., Millington (14)
Beatty, Hannah J., Clinton Farms, Clinton (10)
Beaver, Jennie D., 44 Elm st., Morristown (14)
Bechet, Paul E., 1364 North av., Elizabeth (20)
Becker, C. Frederick, 620 Benson st., Camden (4)
Becker, George L., 646 E. 28th st., Paterson (16)
Becker, Leo V., 69 Ward st., Paterson (16)
Becker, Martin, 66 Hawthorne av., East Orange (7)
Becker, Marvin C., 299 Clinton av., Newark (7)
Becker, Meyer, 219 Amboy av., Metuchen (12)
Becker, Sidney D., 140 Maple pl., Keyport (12)
Becker, Sylvia F., 299 Clinton av., Newark (7)
Bednarz. Stephen, 219 Maple av., Wallington (2)

Bedrick, John J., 945 Avenue C, Bayonne (9)
Behrens, Herman H. E., 312 Webster av., Jer. C. (9)
Beideman, Casper M., 5 W. Maple av.,Merchantv'e(4)
Beim, Norbert, 669 Broadway, Paterson (16)
Beir, Ily R., 3900 Atlantic av., Atlantic City (1)
Beirne, Donald P., 435 N. Arlington av.,E.Orange(7)
Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
Bekampis, Eugene H., 315 E. Maple av., Mech'tv'e(4)
Belafsky, Henry A., 150 Green st., Woodbridge (12)
Belford, Ralph J., 90 Nassau st., Princeton (11)
Beling, C. Abbott, 15 Washington st., Newark (7)
Bell, Horace O., Es. Co. Isola. Hosp., Belleville (7)
Bellak, Ellis R., Leesburg (6)
Belle, Louis, 931 Jefferson av., Elizabeth (20)
Bellis, Horace D., 437 E. State st., Trenton (11)
Belliveau, William J., 269 Morris av., Springf'd (20)
Bellucci, Frank D., 300 Mt. Prospect av., Newark(7)
Belott, August V., 129 Main st., West Orange (7)
Belott, Louis V., 529 Park av., Orange (7)
Bender, Dorothea A., 61 DeHart pl., Elizabeth (20)
Bender, Louis, 285 Ridgewood av., Newark (7)
Bender, Theodore, 666 Broadway, Paterson (16)
Bengelsdorf, Aron, 29 Clinton pl., Newark (7)
Benjamin, Harold C., 59 Crescent av., Jersey City(9)
Benjamin, Joseph F., 203 Godwin av., Ridgew'd(16)
Bensel, Arlington,Jr.,8 Bunny Cir.,Newt'v'le,Mass(7)
Bensley, Maynard G., 129 Summit av., Summit (20)
Bentley, David F., Jr., 406 Cooper st., Camden (4)
Benz, Francis J., 30 Lum av., Chatham (14)
Benz, George L., 251 S. Tenth st., Newark (7)
Berardinelli, Carmine G., 92 Eighth av., Newark(7)
Berenson, Samuel J., 1012 E. Jersey st., Elizab'th(20)
Beres, Albert J., 189-A Valley Blvd., Wood-Ridge(2)
Berg, Samuel, 156 Roseville av., Newark (7)
Bergen, Marshall, 100 Bentley av., Jersey City (9)
Berger, William A., 346 Roseville av., Newark (7)
Bergman, Meyer W., 31 Lincoln Park, Newark (7)
Bergmann, Ewald H., 44 Bank st., Sussex (19)
Bergmeyer, Josef T., 6500 Palisade av., W. N. Y.(9)
Bergsma, Daniel, State Health Dept., Trenton (11)
Berk, M. David, 505 Wanaque av., Pompton L. (16)
Berke, Raynold N., 430 Union st., Hackensack (2)
Berkhout, Peter G., 106 Haledon av., Prospect P.(16)
Berkow, Abraham, 417 Main st., Hackensack (2)
Berkow, Bori, 245 State st., Perth Amboy (12)
Berkow, Samuel G., 280 Hobart st., Perth Amboy(12)
Berkowitz, Benj., 188 E. Commerce st.,Bridgeton(6)
Berlin, Joseph I., 2600 Boulevard, Jersey City (9)
Berlin, Morris R., 84 Girard pl., Newark (7)
Berliner, Harry M., Veterans Adm., Lyons (18)
Berman, H. Robert, 299 Clinton av., Newark (7)
Berman, Jacob J., 409 Market st., Trenton (11)
Berman, Leonard M., 382 Springfield av.,Summit(20)
Berman, Sol, 351 Rahway av., Elizabeth (20)
Bernell, Stanley P., 1207 Haddon av., Camden (4)
Berner, Benjamin, 465 Park av., Paterson (16)
Berney, Irving, 31 Lincoln Park, Newark (7)
Berney, Ruth V., 16 Lyons av., Newark (7)
Bernhard, William G., 79 Minninsink rd., Short H.(7)
Bernheisel, Louis E., Marshallville rd., Tuckahoe(5)
Bernson, Samuel T.,505 Wanaque av.,Pompt'n L.(16)
Bernstein, Arthur, 89 Lincoln Park, Newark (7)
Bernstein, Benedict J.,Ellza.-Carteret Hotel,Ellz.(20)
Bernstein, Bertram, 329 Clearfield av., Trenton (11)
Bernstein, Israel, 95 Wilson av., Newark (7)
Bernstein, Julius, 584 S. Tenth st., Newark (7)
Berry, C. Hartley, 129 Summit av., Summit (20)
Bertha, Nicholas A., 83 S. Main st., Wharton (14)
Bertland, Alex. D., 142 Belvidere av., Wash'gt'n(21)
Besson, Franklin J., 999 Clinton av., Irvington (7)
Betancourt, Raul R., 406 Cooper st., Camden (4)
Betsch, William F.,220 Pleas'nt Val.av.,Moorest'n(3)
Betts, R. Winfield, 22 N. Main st., Medford (3)
Bew, David F., 7500 Ventnor av., Margate City (1)
Bew, Richard C., 1217 Pacific av., Atlantic City (1)
Bianchi, Angelo R., 184 Hunterdon st., Newark (7)
Bianco, John J., 318 Cooper st., Camden (4)
Biber, David, 900 Stuyvesant av., Union (20)
Bibighaus, Warren Y., 313 4th av., Haddon Hts. (4)
Biezak, Arkad K., 311 Lexington av., Clifton (16)
Bieber, Harold B., 115 Fairview av., Jersey City (9)
Bigliani, Urban R., 7308 Boulevard, N. Bergen (9)
Binder, Charles I., 833 South 13th st., Newark (7)
Binder, Joseph, 101 Third av., Long Branch (13)
Bird, Frank L., 8 Main st., Netcong (14)
Bird, Frank L., Jr., 8 Main st., Netcong (14)
Bird, Ivan F., 1213 Hamilton av., Trenton (11)
Birrell, Russell G., 56 Church st., Toronto 1,Can.(20)
Bissett, John V., 29 Hawthorne av., East Orange(7)
Biunno, Anthony J., 61 Hillcrest ter., E. Orange (7)
Black, LeRoy W., 33 W. Passaic av., Rutherford(2)
Black, Maskell B., 128 E. High st., Glassboro (8)
Blackburne, George, 490 Central av., Newark (7)
Blackman, Sadie, 12 Roosevelt av., Westwood (2)
Blackwell, Enoch, 28 W. State st., Trenton (11)
Blaisdell, C. Byron, 489 Broadway, L. Branch (13)
Blake, Albert J., 640 Broadway, Paterson (16)
Blake, Dexter B., R. F. D. 1, Far Hills (14)
Blakey, Abram P., 144 Wegman Pkwy., Jer. City (9)
Blanchard, Kenneth, 144 Harrison st., E. Orange (7)
Blasi, Benjamin, 150 Hunterdon st., Newark (7)
Blasi, Clifford, 26 Longfellow av., Newark (7)
Blatt, David, 737 Jefferson av., Elizabeth (20)
Blaugrund, Samuel, 833 W. State st., Trenton (11)
Blaustein, Maurice L., 859 S. 13th st., Newark (7)
Bleasby, Charles B., 136 Passaic st., Garfield (2)
Blecher, Irving E., Veterans Admin., Lyons (18)
Bleiberg, Jacob, 31 Lincoln Park, Newark (7)
Blenkle, Victor A., 140 Chadwick rd., Teaneck (2)
Bloch, Harry, 613 N. Broad st., Elizabeth (20)
Block, Charles, 368 Clinton av., Newark (7)
Block, Marcus T., 177 Bloomfield av., Newark (7)
Block, Max, 48 N. Fullerton av., Montclair (7)
Block, Milton, 320 Union av., Irvington (7)
Bloom, G. Homer, 674 Hillcrest Blvd., Phillipsb'g(21)
Blumberg, A. William, New Egypt (15)
Blumberg, Jack, 504 Westminster av., Elizabeth(20)
Blythe, Rowland P., 30 Springf'd av., Cranford (20)
Bobadilla, Juan E. B., 293 S. Main st., Wharton (14)
Bocchini, Joseph A., 366 S. 12th st., Newark (7)
Boehm, Herbert, 610 Salem av., Elizabeth (20)
Bogacz, John, 3288 Boulevard, Jersey City (9)
Bohl, Louis J., 320 Broadway, Paterson (16)
Bokor, Emery, 819 S. 12th st., Newark (7)
Boland, Lucy E., 27 Washington av., Arlington (9)
Bolanowski, Kasimier J., 145 Marsh'l st.,Ellz'b'h(20)
Bolten, Bernard, 377 Osborne ter., Newark (7)
Bomar, Wirrion, 419 Spooner av., Plainfield (20)
Bombardieri Anthony, 251 Centre st., Nutley (7)
Bonanno, Peter J., 226 Engle st., Englewood (2)
Bongiorno, Henry D., 516 River st., Paterson (16)
Bonnet, W. Laurence,2791 Not'gh'm wy.,M're'rv'e(11)
Bonomo, Michael J., 587 S. Tenth st., Newark (7)
Boogdanian, Victor H.,316 George st.,N.Br'nsw'k(12)
Booken, Gerald J., 1 Johnson av., Newark (7)
Bookrajian, Edward N., 8027 Boulevard,N.Bergen(9)
Bookstaver, Barnet S., 241 Cedar lane, Teaneck (2)
Booth, Herbert W., 4th & Jersey avs., Spring L.(13)
Booth, Walter S., 744 Rahway av., Elizabeth (20)
Booth, William K., 304 William st., Boonton (14)
Boquist, Walter A., 380 Hudson st., Phillipsb'g(21)
Borak, Peter, Merck & Co., Rahway (20)
Borkow, Philip, 45 E. Blackwell st., Dover (14)
Bornstein, David, 566 Broadway, Paterson (16)
Bornstein, Paul K., 601 Grand av., Asbury Pk. (13)
Borow, Benjamin, 507 Church st., Bd. Brook (18)
Borow, Henry, 507 Church st., Bound Brook (18)
Borow, Louis S., 507 Church st., Bound Brook (18)
Borow, Maurice, 524 Church st., Bound Brook (18)
Borrella, Dominic D., 476 Hamilton av., Trenton (11)

Borrone, Milton G., 2624 Boulevard, Jersey City (9)
Borrus, Joseph C., 105 Carroll pl., N. Brunsw'k (12)
Borshaw, Hyman, 108 Bentley av., Jersey City (9)
Borsher, Irving P., 306 Ridge st., Newark (7)
Bortone, Frank, 2765 Boulevard, Jersey City (9)
Bosch, Donald T., 244 Woodside av., Ridgewood (7)
Bosch, Taeke, 290 E. Franklin Tpk., Hohokus (2)
Boselli, Emile H., 614 15th st., Union City (9)
Bossard, Harry B., R. D. 2, Phillipsburg (21)
Bostwick, Delazon S., Cumberland Htl.,Bridget'n(6)
Bostwick, Wallace R., Main st., Blairstown (21)
Botbyl, Burt W., 927 Madison av., Paterson (16)
Botti, John A., 157 Wegman Pkwy., Jersey City (9)
Boudwin, Norman K., 64 Church st., Beverly (3)
Bourns, Edward G., 203 S. Euclid av., Westfield(20)
Bove, Joseph, 306 Lincoln av., Orange (7)
Bowen, Robert N., 419 Cooper st., Camden (4)
Bowers, F. Clyde, Mountain av., Mendham (14)
Bowersox, Clarence A., 509 N. Broad st.,W'dbury(8)
Bowman, Ned O., 1001 Georges rd., N. Brunsw'k(12)
Boyd, John B., 31 Oakland st., Red Bank (13)
Boyd, Robert P., 210 Martine av., S., Fanwood (20)
Boyd, William B., Jr., N. J. Zinc Co., Franklin (19)
Boyer, Charles G., Annandale (10)
Boyer, Paul K., 129 Summit av., Summit (20)
Boyers, Sidney S., 413 60th st., West New York (9)
Boyes, James G., Inman av., Plainfield (20)
Boylan, Matthew E., 66 Van Reypen av., Jer. City(9)
Boyle, Francis L., 805 Boulevard, Bayonne (9)
Boysen, Otto T., 2704 Westfield av., Camden (4)
Bozzi, Robert, 406 Roseville av., Newark (7)
Brackett, Elizabeth R., 371 Franklin av., Nutley (7)
Bradasch, George A., 1415 Central av., Union C. (9)
Bradford, Stella S., 26 N. Mountain av., Montcl'r(7)
Bradley, Muriel, 126 Lorraine av., Up. Montclair (7)
Bradley, Robert A., 1616 Pacific av., Atlantic City(1)
Brady, Frank J., 1038 S. Orange av., Newark (7)
Brady, Thomas S., 678 Avenue C, Bayonne (9)
Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
Bramble, Halsey S., Front & Ch'tn't sts., Elmer (17)
Brams, William M., 7 Madison av., Newark (7)
Brancone, Alphonse M., 417 21st av., Paterson (16)
Brandman, Otto, 190 Clinton av., Newark (7)
Branin, Howard S., 200 W. Main st., Millville (6)
Brasefield, Edgar N., 218 Chamb'rs st.,Phillipsb'g(21)
Brauer, Charles, 2219 Boulevard, Jersey City (9)
Brauer, Selig L., 2012 Boulevard, Jersey City (9)
Braun, David C., 51 Trinity st., Newton (19)
Braun, Gustav A.,269-A Harrison G'd'ns,E.Orange(7)
Braun, Joseph C., 531 Broad av., Palisades Pk. (2)
Braun, William, 406 Cooper st., Camden (4)
Braunstein, Sigmund C., 424 57th st., W. N. Y. (9)
Braunstein, William P., 1 Bellevue st.,Weeh'wk'n(9)
Braunwarth, Robert J., 555 S. Broad st.,Elizab'th(20)
Brawer, Jerome, 425 Park av., Paterson (16)
Bray, William E., 41 Elizabeth st., Pemberton (3)
Bregman, Alexander, 2 Dempsey av., Edgewater (2)
Bregman, Milton, 81 Union av., Manasquan (13)
Breme, Julius C., 523 Walnut av., Laurel Springs(4)
Bremer, Kenneth M.,85 S. Harrison st.,E.Orange(7)
Brenna, Joseph D., 448 Hamilton av., Trenton (11)
Brennan, Charles L. S., 14 S. Broadway, Glouc'st'r(4)
Brennan, John P., 14 Church rd., Merchantville (4)
Brennan, Ralph J., 301 Plaza rd., Fair Lawn (2)
Brescia, James, 7 E. Franklin Tpk., Waldwick (2)
Bresev, Morris, 42 Broadman Parkway, Jer. City (9)
Breslow, Alexander E., 930 Pierpont st., Rahway(20)
Breslow, Samuel, 157 Market st., Perth Amboy (12)
Brethwaite, Samuel H., Jr., 129 Summit av.,S'm't(20)
Breuder, Andrew B., Whippany rd., Whippany (14)
Brewer, Catherine H., 808 Ocean av., Jersey City (9)
Brewer, David R., Jr., 112 N. Broad st.,Woodbury(8)
Brezinski, Edward J., 308 Wash'gt'n st.,P.Amboy(12)
Brick, George J., 43 Cottage st., Jersey City (9)
Briggs, Henry, 144 Harrison st., East Orange (7)
Brill, Robert, Saint Mary's Hospital, Passaic (16)
Brim, Anne J. S., Edgemere Hotel, E. Orange (7)
Brindle, Harry R., 501 Grand av., Asbury Park (13)
Brinning, Elbert C.,Jr.,442 Washington av.,M'tcl'r(7)
Bristol, Frank E., II, Main st., Dayton (12)
Brittain, Elmore G., 15 W. Bridge st., Bound Br'k(18)
Brizard, Joseph L., 81 High st., Belleville (7)
Brock, Howard F., 417 W. Broad st., Westfield (20)
Brodkin, Eva T., 365 Osborne ter., Newark (7)
Brodkin, Henry A., 365 Osborne ter., Newark (7)
Brody, Morton S., 67 Paterson st., N. Brunsw'k(12)
Brogan, Francis B., 600 Broadway, Paterson (16)
Brokaw, Christopher A., 615 N. Broad st.,Eliz'b'h(20)
Bromberg, Charles B., 107 Lexington av.,Passaic(16)
Bromberg, Jules H., 89 Lincoln Park, Newark (7)
Bronner, Alfred, 47 Burgess pl., Passaic (16)
Brooks, George M., 18 N. Main st., Cape May Ct.H.(5)
Brooks, Sidney S., 380 12th av., Paterson (16)
Brotman, Morton M., 90 Avon av., Newark (7)
Brower, Francis M., III, 37 E. Center st.,Woodb'y(8)
Brown, Chester R., 22 Midland av., Arlington (7)
Brown, Francis S., 2216 Shore rd., Northfield (1)
Brown, Frank H., Jr., 327 Chestnut st., RoselleP.(20)
Brown, Harold W., 27 S. Fullerton av., Montclair (7)
Brown, J. Carlisle, 1616 Pacific av., Atlantic City(1)
Brown, John L., 1019 Cumbermede rd., Palisade (2)
Brown, Kenneth G., 501 Grand av., Asbury Park(13)
Brown, L. Greeley, 173 Madison av., Elizabeth (20)
Brown, Lewis W., 160 Roseville av., Newark (7)
Brown, Marcus, 2 Wt. Horse Pk., Haddon Hts. (4)
Brown, Milton B., 72 Roosevelt av., Carteret (12)
Brown, Robert C., 318 N. Second st., Millville (6)
Brown, Stanley L., 517 Cooper st., Camden (4)
Brown, William H., 501 First av., Elizabeth (20)
Browne, George F., 126 Lorraine av., U. Montcl'r(7)
Browning, Wm. J., 134 N. Center st.,Merchantv'le(4)
Brozdowski, John J., 562½ Jersey av., Jer. City (9)
Brozyna, Mieczyslaw, 194 Carlton av.,E. Rutherf'd(2)
Brunhofer, Andrew, 714 Cedar lane, Teaneck (2)
Bruning, Richard H., 372 Wyoming av.,Maplew'd(7)
Brunkow, Charles D., 31 Lincoln Park, Newark (7)
Brunner, Hans, 670 Clinton av., Newark (7)
Bruno, Anthony, 1092 Elizabeth av., Elizabeth (20)
Bruzza, George, 415 Washington Blvd., Sea Girt (13)
Buchan, Ronald F., Prudential Insur. Co.,New'k(7)
Buchanan, Ralph M. L., 8 Market st., Phillipsb'g(21)
Buchanan, Robert W., 129 Summit av., Summit (20)
Buckley, Jeremiah L., 666 Franklin av., Nutley (7)
Buckley, Paul J., 159 Palisade av., Bogota (2)
Buckley, Richard F., 1122 Garden st., Hoboken (9)
Buckley, Richard T., Jr., 111 E. Main st.,Maple S.(3)
Buckner, Roscoe W. H., 20 Rose st., Newark (7)
Budd, J. Reuben, 230 Lexington av., Passaic (16)
Budnicki, Xavier B., 105 Broad st., Perth Amboy(12)
Buermann, August, III, 153 Irvington av., S. Or. (7)
Buermann, Robert, 206 Madison av., Lakewood (15)
Buffey, W. H., McGuire V.A.Hosp.,Richmond,Va.(20)
Buklad, Henry P., 441 Broadway, Passaic (16)
Bull, Louis M., 7 Brook Lane, Maplewood (7)
Bull, William J., 98 Park st., Montclair (7)
Bullen, Victor E., 148 Hamilton av., Paterson (16)
Bump, Samuel C., 505 E. Ridgew'd av.,Ridgew'd(2)
Bunnell, Frederick N., 22 S. Main st., Barnegat (15)
Burbidge, J. Raymond, 163 Nassau st., Princeton(11)
Burch, Reynold E., 102 S. 14th st., Newark (7)
Burke, Leonard P., 76 Lakeside av., Verona (7)
Burke, Stephen E., 212 First av., Newark (7)
Burkett, J. Paul, 215 Delaware st., Woodbury (8)
Burkett, Wendell J., 16 W. Holly av., Pitman (8)
Burkhead, Howard C., 541 Broadway, L. Branch(13)
Burn, Victor E., 27 Trinity st., Newton (19)
Burne, John J., 17 Gould av., Newark (7)
Burnett, Lawrence F., 386 Roseville av., Newark(7)
Burnham, Lyman, 229 Engle st., Englewood (2)
Burns, Geoffrey C. H., County rd., Demarest (2)

Burns, Joseph R., 254 S. Olden av., Trenton (11)
Burns, Wilmer F., 267 White Horse Pk., Audubon(4)
Burokus, William, 21 E. Pleasant av., Maywood (2)
Burpeau, William P., 80 Woodland av., E. Orange(7)
Burrill, Benjamin B., Jr., 83 Park st., Montclair(7)
Burritt, Norman W., 382 Springfield av.,Summit(20)
Burroughs, Charles W.,688 Stuyves't av.,Trent'n(11)
Burroughs, Edmund W., 701 W. State st.,Trent'n(11)
Burstein, Frank, 1115 S. Broad st., Newark (7)
Burstein, Leo Q., 115 Jefferson av., Elizabeth (7)
Burstein, Rachel, 31 Lincoln Park, Newark (7)
Busansky, Samuel T., Trenton rd., Browns Mills(3)
Busch, Herman, 32 Johnson av., Newark (7)
Bush, Archer C., 40 Union st., Montclair (7)
Bush, Ralph K., 23 E. Maple av., Merchantville (4)
Busicco, Philip S., 131 Liberty rd., Englewood (2)
Butan, Louis, 479 Highland av., Orange (7)
Butcher, Charles, Heislerville (6)
Butenas, Joseph J., 300 First av., Elizabeth (20)
Butler, Samuel S., 1100 Kaighn av., Camden (4)
Butler, Vincent P., 33 Bentley av., Jersey City (9)
Butterfield, Arey A., 655 Main av., Passaic (16)
Buvinger, Charles W., 50 Washington st., E. Or.(7)
Byck, Louis, 794 S. 11th st., Newark (7)
Byer, M. Yale, 442 Greenwood av., Trenton (11)
Byrne, Francis, Jr., 35 Park av., W. Orange (7)
Byrne, J. Arthur, 16 Elm st., Morristown (14)
Byrnes, Elizabeth W., 55 S. Maple av., E. Orange(7)
Bythewood, Alton E., Jr., 145 W. Mark't st.,New'k(7)

ASSOCIATE MEMBERS

Babad, Frederick, Tilton Gen. Hosp., Fort Dix (11)
Bacsik, Edward J., 456 Home av., Trenton (11)
Balakian, Gerard, 131 Ayers ct., West Englewood(2)
Benko, George, 266 High st., Perth Amboy (12)
Bibbo, Canio, 130 Kensington rd., River Edge (2)
Bitsack, Joseph W., 210 Main st., Hackensack (2)
Bonelli, Willian R., 30 Brookwood st., E. Orange (7)
Bowen, John R., Jr., 1036 Maple av., Linwood (1)
Bowne, Donald W., 1300 Sunset av., Wanamassa(13)
Brady, Edward A.,Jr.,11Stone st., N. Brunswick (12)
Brodek, Hans D., 218 Broad av., Leonia (2)
Brody, Michael, 228 Livingston av.,N. Brunswick(12)
Burkhardt, Hans E., 1616 Pacific av., Atl. City (1)

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ACTIVE MEMBERS

Cacciarelli, Robert A., 517 Roseville av., Newark(7)
Cagan, Maclyn, 60 Ridge rd., North Arlington (7)
Caggiano, Anthony P., 137 Grove st., Montclair (7)
Caggiano, John D., 140 W. Main st., Penns Gr.(17)
Cahill, Laurence A., 361 Lafayette st., Newark (7)
Calabrese, Dino, 1022 Anderson av., Palisade (2)
Calasibetta, Charles J., 37 Longfellow av., New'k(7)
Caldwell, Delma, Standard Oil Co., Linden (20)
Caldwell, Donald M., 219 N. Arlington av., E. Or. (7)
Caldwell, George W., 81 E. Clinton av., Tenafly (2)
Caldwell, Julius A., 45 S. Mountain av., Montclair(7)
Caleca, Jack J., Andover (19)
Callahan, Edward J., 124 St. Paul st., Westfield (20)
Calligaro, Egildo A., 288 Parker av., Clifton (16)
Calvert, William C., 225 Gregory av., W. Orange (7)
Calvin, Charles H., 80 Commerce st., P. Amboy(12)
Camarda, Joseph, P. O. Box 215, Lakehurst (15)
Camche, Leo J., 250 Renner av., Newark (7)
Cameron, Arthur E., 59 Somerset st., Newark (7)
Cameron, C. Paul, 720 Shore rd., Somers Point (5)
Cameron, Joseph H., 720 Shore rd., Somers Pt. (1)
Campana, Vincent R., 386 Fairmount av.,Jer.City(9)
Campbell, Charles P., 397 Prospect av., Hackens'k(2)
Campbell, Everette L., 144 Harrison st., E.Orange(7)
Campbell, James M., 101 S. Central av., Ramsey (2)
Campbell, William, 144 Harrison st., E. Orange (7)
Campo, A. Guy, 401 Broadway, Westville (8)
Campo, Salvatore T., 200 Broadway, Westville (8)
Canaan, Robert, 12-18 River rd., Fair Lawn (16)
Candio, Vincent P., 366 Ridge rd., Lyndhurst (2)
Cannata, Benjamin, 113 Market st., P. Amboy(12)
Cannis, John P., 1019 Park av., Plainfield (20)
Cannon, Edward A , 7512 Boulevard, N. Bergen (9)
Cantalupo, Emidio, 95 Nichols st., Newark (7)
Cantelmo, Alphonse L., 144 Harrison st., E. Or. (7)
Cantini, Raphael S., 727 Watchung av., Plainf'd(20)
Capell, Harry H., 302 Broadway, Paterson (16)
Capio, Mario D., 293 Broadway, Paterson (16)
Cappiello, William, 352 Seventh av., Newark (7)
Caprio, Orlando G., 428 Third av., Newark (7)
Captanian, Aram A., 166 Main st., Matawan (13)
Caputo, Anthony R., 301 Washington av.,Bellev'le(7)
Carabelli, A. Albert, 306 Hamilton av., Trenton(11)
Carbone, Francesco N., 440 Central av., Orange(7)
Card, Charles F., 144 W. Milton av., Rahway (20)
Cardinale, Pasquale F., 1405 North av., Elizabeth(20)
Cardwell, Edgar P., 965 Broad st., Newark (7)
Carey, David S., 11 E. Main st., Freehold (13)
Caridi, Salvatore, 431 59th st., West New York (9)
Carlander, Oswald R., 130 N. Broadway, Camden (4)
Carlisle, J. Mallory, 550 Hillcrest av., Westfield (20)
Carll, Jesse W., 129 Broad st., Bridgeton (6)
Carlough, David J,, 426 Ellison st., Paterson (16)
Carman, Henry E., 37 Selvage av., W. Englewood (2)
Carmona, L. Roberto, 141 Wood st., Tuckerton (15)
Carmona, Manuel G., 141 Wood st., Tuckerton (4)
Carnrick, Millard, Jr., 14 Freeman st., Roseland (7)
Caro, Eugene P., 926 Wood av., N., Linden (20)
Carpenter, Cedric C., 97 Hobart av., Summit (20)
Carpenter, Marcus E., 99 Storms av., Jersey City(9)
Carr, Josephus C., 75 13th av., Newark (7)
Carr, Mary B., 1 Astor pl., Jersey City (9)
Carrigan, Francis P., 305 Roseville av., Newark (7)
Carrol, Wilfred, 51 Ingraham pl., Newark (7)
Carroll, Bruce J., 469 W. Front st., Plainfield (20)
Carroll, C. Walter, 125 Centre st., Trenton (11)
Carroll, William V., 211 Academy st., Trenton (11)
Carsley, Sidney H., 19 Holly st., Cranford (20)
Carter, Joseph F. S., 142 Atkins av., Asbury Pk.(13)
Cartisser, Joseph J., Stanhope (19)
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge(2)
Carusi, Leonardo G., 337 Park av., Paterson (16)
Caruso, Anthony T., 304 Union av., Belleville (7)
Caruso, Paul F., 194 Montross av., Rutherford (2)
Casagrande, Stephen R., 56 River rd., Rumson (13)
Casciano, Adolph D., 189 Harrison av., Jersey C.(9)
Case, Clarence E., Jr., 15 W. Bridge st., Som'rv'e(18)
Casey, Robert B., 51 W. Milton av., Rahway (20)
Casilli, Arturo R., 618 Newark av., Elizabeth (20)
Casselman, Arthur J., 301 N. Second st., Camden (4)
Casser, Leonard, 85 Margie av., Cresskill (2)

Cassini, Henry C., 27 Tremont av., East Orange (7)
Castaldo, Neil, 103 Lincoln av., E., Cranford (20)
Castellano, Martin G., 330 Roseville av., Newark(7)
Catania, Joseph P., 140 Passaic st., Garfield (2)
Catanzaro, Francesco, 151 Jefferson st., Passaic(16)
Catanzaro, Vincent J., 316 Midland av., Garfield (2)
Catapano, John, 21 Hazelton st., Ridgefield Pk. (2)
Cates, Haynes B., Shell rd., Penns Grove (17)
Catlaw, J. Kenneth, 321 Stegman Pkwy., Jer. City(9)
Catlett, George F., Newton (19)
Cebula, Jerome M., 7332 Boulevard, No. Bergen (9)
Cella, Charles F., 359 Hamilton av., Trenton (11)
Cerchio, Michael, 132 Wayne st., Jersey City (9)
Cerone, Daniel M., 365 Roseville av., Newark (7)
Cestone, Canio, 1425 Pompton av., Little Falls (7)
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark (7)
Chaiken, Louis H., P. O. Box 51, Elizabeth (20)
Chalfant, William P., Br'dw'y & Craft'n av.,Pitm'n(8)
Chamberlain, Richard R., 30 Lenox pl., Maplew'd(7)
Chandler, Swithin, Jr., 4273 S. Broad st.,Yardv'e(11)
Chapman, Ellis J., 203 Danforth av., Jersey City(9)
Chapman, Otis P., 400 Westminster av.,Elizab'h(20)
Chapman, Walter I., 700 Avenue C, Bayonne (9)
Chapnick, Maurice M., 715 Broadway, Paterson(16)
Charleroy, Durant K., 935 Greenw'd av., Trenton(11)
Charlton, C. Coulter, 1616 Pacific av., AtlanticCity(1)
Charney, William, 555 Broadway, Paterson (16)
Chase, Anthony V., 220 S. Main st., Manville (18)
Chase, Kalman, Jr., 80 Sheridan av., Hohokus (2)
Chayes, Sydney, 980 Avenue C, Bayonne (9)
Chernus, Jack, 61 Lincoln Park, Newark (7)
Cherry, Homer H., Val. View Sana., Paterson (16)
Cheskin, Louis J., 31 Lincoln Park, Newark (7)
Chesler, Maurice, 124 W. Broadway, Salem (17)
Chesley, Norman K., 211 E. Main st.,Maple Shade(8)
Chesner, William A., 1111 Hamilton av., Trenton(11)
Chester, Saul W., 634 Broadway, Paterson (16)
Chianese, C. Chester, 464 Hamilton av., Trenton(11)
Chiaramida, Joseph, Essex Co. Sana., Verona (7)
Chieffo, Henry, 1722 Boulevard, Union City (9)
Chiger, Alexander S., 621 High st., Newark (7)
Childers, Robert J., 604 Park av., Plainfield (20)
Chilton, Forrest S., Pompton Tnpk.,Pompton P.(16)
Chimacoff, Hyman, 159 Elizabeth av., Newark (7)
Chizik, John J., 162 W. 31st st., Bayonne (9)
Chmelnik, Abraham G., City Hospital, Newark (7)
Chodosh, Maurice A., 606 Roosevelt av., Carteret(20)
Chrisman, Irving, 423 Broadway, Paterson (16)
Christensen, Alexander H., Lebanon (10)
Christian, Elizabeth I., Station A, Trenton (11)
Christian, Henry A., 263 Woodlawn av., Jer. City (9)
Christoph, Francis T., 959 Salem rd., Union (7)
Chromow, Bernard, 95 Wilson av., Newark (7)
Chudzik, Edward W., 269 Outwater lane, Garf'd(16)
Church, Charles F., 192 College av., N. Brunsw'k(12)
Churg, Jacob, Barnert Mem. Hosp., Paterson (16)
Ciampa, Ralph P. E., 119 Morris av., L. Branch (13)
Ciccone, Anthony C., 389 Grand st., Paterson (16)
Ciccone, Edwin L., 261 Roseville av., Newark (7)
Ciccone, Roy, 57 Passaic av., Passaic (16)
Cichon, Elmer J., 679 Van Houten av., Clifton (16)
Cicione, Edward, 621 Highland av., Palmyra (3)
Cieri, Daniel S., 1515 Central av., Union City (9)
Ciliberti, Frank J., Jr., 5th & Pine sts., Camden (4)
Cincotti, Victor, 11 Hill st., Newark (7)
Citrino, Robert J., 345 Centre st., Nutley (7)
Clarie, D'Arcy C., 558 Broad av., Ridgefield (2)
Clark, Alice L., 206 W. State st., Trenton (11)
Clark, Ernest W., 414 Cooper st., Camden (4)
Clark, Frank G., White House Station (10)
Clark, John C., 501 Grand av., Asbury Park (13)
Clark, Margaret A., Glen rd., Woodcliff Lake (2)
Clark, Morris B., W. Pine & Atl. avs., Audubon (4)
Clark, Orlo H., 149 Prospect st., Passaic (16)
Clark, S. Worth, 152 S. No. Carolina av., Atl. C. (1)
Clarke, Francis M., 116 New st., N. Brunsw'k (12)
Clarken, Joseph A., 27 Ingraham pl., Newark (7)
Cleary, Joseph P., Minotola (1)
Clement, Baxter L., 15 Washington st., Newark (7)
Clinton, James, N. J. State Hosp., Marlboro (12)
Clinton, Joseph A., 339 Park av., Newark (7)
Close, Byron H., Hamburg Tnpk., Bloomingdale (16)
Cloud, Albert W., 139 Hugenot av., Englewood (2)
Clunan, Ambrose P., 851 Hamilton av., Trenton (11)
Coburn, J. Wesley, 144 Harrison st., E. Orange (7)
Cockburn, Wilfred P., 48 East Kinney st.,Newark(7)
Coe, Edward M., 217 Holly st., Cranford (20)
Coes, Harold V., Jr., R.F.D. 2, Sussex (19)
Coffin, Henry F., 116 N. Ninth st., Newark (7)
Coggeshall, Bayard, 20 Elm st., Morristown (14)
Cohan, Charles C., 217 W. Hanover st., Trenton (11)
Cohen, Harry X., 1267 Stuyvesant av., Union (20)
Cohen, Herman, 489 Jersey av., Jersey City (9)
Cohen, Herman, 1301 Hamilton av., Trenton (11)
Cohen, Herman N., 108 13th st., Hoboken (9)
Cohen, I. Elvin, 561 Elizabeth av., Newark (7)
Cohen, Julian, 592 E. 29th st., Paterson (16)
Cohen, Leon, 2424 Baird Blvd., Camden (4)
Cohen, Louis, 257 Paulison av., Passaic (16)
Cohen, M. Marvin, 582 E. 25th st., Paterson (16)
Cohen, Maurice. 106 Valley rd., Montclair (7)
Cohen, Maurice B., 224 E. Wildwood av., Wildw'd(5)
Cohen, Oscar H., 115 Church st., Boonton (14)
Cohen, Paul, 500 State st., Camden (4)
Cohen, Samuel, 100 Clifton pl., Jersey City (9)
Cohen, Samuel A., 980 Summit av., Jersey City (9)
Cohen, Sidney L., 29 Girard pl., Newark (7)
Cohen, Sidney P., 509 Franklin av., Nutley (7)
Cohen, William, 1007 Greenwood av., Trenton (11)
Cohn, Hermann, 393 Clinton av., Newark (7)
Cohn, Isidor, 231 Lexington av., Passaic (16)
Cohn, Royal M., 740 Clinton av., Newark (7)
Colavita, James J., 433 Princeton av., Trenton (11)
Cole, Harold S., 19 Donaldson av., Rutherford (2)
Cole, L. Frank, 388 Terhune av., Passaic (16)
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth(20)
Coleman, Austin H., 93 Center st., Clinton (10)
Coleman, Joseph G., Hamburg (19)
Coleman, Russell M., 76 N. Clinton st., E. Orange(7)
Colfax, Richard S., 33 Bartolf av.,PomptonLakes(16)
Colley, Arthur T., 916 Park av., Plainfield (20)
Collier, Martin H., 406 Cooper st., Camden (4)
Collins, John F., 1208 Columbia av., Pleasantv'e(1)
Collins, Laurence M., N. J. State Hosp., Grey.P.(14)
Collins, Louis K., 54 State st., Glassboro (8)
Collis, Abraham S., 156 Atlantic av., L. Branch (13)
Colonna, Joseph A., 5016 Hudson av.,W.NewYork(9)
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood(7)
Colton, Ethan T., Jr., 31 Park st., Montclair (7)
Comando, Edward N., 695 Clinton av., Newark (7)
Comando, Harry N., 695 Clinton av., Newark (7)
Comeau, George W., 415 Speedw'l av.,Mor's Pl'ns(14)
Comfort, John B., 50 S. Clinton av., Trenton (11)
Commini, Frank F., 439 Bellevue av., Trenton (11)
Comunale, Anthony R., 1709 Irving st., Rahway(20)
Cone, Thomas E., Jr., 108 N. Stanw'th dr.,Pr'c't'n(11)
Conlen, Richard, 523 Haddon av., Camden (4)
Conlon, Philip J., 25 James st., Newark (7)
Connamacher, Harold S., 671 Springf'd av.,New'k(7)
Connell, Emmet J., 2227 Boulevard, Jersey City (9)
Connell, James, 337 Monmouth st., Gloucester (4)
Connell, John N., 26 Carlton av., Jersey City (9)
Conner, Herbert A., 222 Bastogne sq., Newark (7)
Connolly, John J., 180 Ballantine Pkwy., Newark (7)
Connolly, Joseph A., 124 Firth st., S. Plainfield (20)
Connolly, Joseph P., 56 Hamilton st., Paterson (16)
Connolly, Richard N., 117 Fifth st., Newark (7)
Conover, Elizabeth, 129 Summit av., Summit (20)
Conserva, Peter V., 196 Randolph av., Clifton (16)
Constad, Arnold N., 944 Stuyvesant av., Union (20)

Conti, Horace, Vet. Adm. Center, Biloxi, Miss. (7)
Conti, Michael, 280 Fourth st., Jersey City (9)
Conty, Anthony J., 318 48th st., Union City (9)
Conway, James V., 428 Elmora av., Elizabeth (20)
Cook, Caroline S., 27 E. Cliff st., Somerville (18)
Cook, Dora G., 317 Cornelia st., Boonton (14)
Cook, Homer E., 27 E. Cliff st., Somerville (18)
Cook, Hugh F., 21 Roseville av., Newark (7)
Cooley, Justice H., II, 150 W. High st.,Somerville(18)
Cooper, Howard M., 37 Ridge rd., Rutherford (2)
Cooper, Irving J., 419 George st., N. Brunsw'k (12)
Cooper, Jehu P., Box 74, Matawan (13)
Cooper, Ray C., 173 E.Wash'gt'n av., Wash'gt'n(21)
Cooper, Robert A., 7137 E. Park av.,Penns'k'nTsp.(4)
Cooperman, Eli L., 527 N. Brunswick av., Fords(12)
Cooperman, William, 647 Market st., Newark (7)
Copleman, Benjamin, 280 Hobart st., P. Amboy (12)
Copleman, Hyman B.,111 Liv'gst'n av.,N.Br'sw'k(12)
Coplin, George J., 528 E. Jersey st., Elizabeth (20)
Corbusier, Harold D., 612 Park av., Plainfield (20)
Coriell, Lewis L., Municipal Hospital, Camden (4)
Corio, George A., 307 S. Clinton av., Trenton (11)
Corless, Joseph F., 7 77th st., North Bergen (9)
Corn, David, 541 Queen Anne rd., Teaneck (2)
Cornish, Charles H., 673 Prospect st., Maplewood(7)
Cornwell, Robert A., 717 Wesley av., Ocean City (5)
Corrigan, Patrick H., 1720 S. Broad st., Trenton(11)
Corson, Filbert R., 101 S. Indiana av., Atl. City (1)
Corson, Kenneth E., 25 S. Myrtle st., Vineland (6)
Cortese, Alvin E., 26 Ward st., Paterson (16)
Cosgrove, Robert A., 186 Belmont av., Jer. City (9)
Cosgrove, Samuel A., 88 Clifton pl., Jersey City(9)
Costa, George J., 567 Jersey av., Jersey City (9)
Costa, Philip L., 88 East Front st., Red Bank (13)
Costabile, Vincent, 324 Second av., Lyndhurst (2)
Costanzo, Joseph J., White Horse av., Clementon(4)
Costello, William F., 55 W. Blackwell st., Dover(14)
Cosulich, Livio, 181 Harding dr., South Orange (7)
Cottone, R. John, 683 Princeton av., Trenton (11)
Cottrell, Judson G., 159 Market st., Perth Amboy(12)
Coughlan, Ella A., 10 Oakwood av., Orange (7)
Coughlin, Frank J., 100 Magnolia av., Arlington(7)
Coughlin, Joseph J., 396 Union st., Hackensack (2)
Coultas, Aldo B., 1 Madison av., Madison (14)
Covino, Louis L., 44 Oakland ter., Newark (7)
Cowen, Mortimer I., 1330 Oak Tree rd., Iselin (12)
Cowlbeck, H. Donald, 224 W. State st., Trenton (11)
Cox, J. Robert, 37 W. Main st., Penns Grove (17)
Cox, John C., 55 Woodland rd., Maplewood (7)
Cox, William T. R., 345 S. Broad st., Elizabeth (20)
Cox, William W., 79 S. Fullerton av., Montclair (7)
Coxson, Harold P., Laurel rd., Stratford (4)
Cozzarelli, James J., 219 Belleville av., Belleville (7)
Crabtree, Loren H., 505 Jersey av., Elizabeth (20)
Cracco, Frederick A., 211 Palisade av., Union City(9)
Crandall, John K., 200 Main st., Fort Lee (2)
Crane, Bernard, 306 Pacific av., Atlantic City (1)
Crane, Charles G., 78 Farley av., Newark (7)
Crane, Norman T., 1025 Sleepy Hol. ln., Plainf'd(20)
Crane, Warren E., 974 S. Broad st., Trenton (11)
Crapanzano, Domenico, Essex Co. Hosp.,Cedar G.(7)
Craster, Charles V., Plane & William sts., New'k (7)
Crater, Kenneth E., 172A Davey st., Bloomfield (7)
Crawford, Georgina U., 65 Prospect st., E. Orange(7)
Crecca, Anthony D., 376 Roseville av., Newark (7)
Crecca, Joseph V., 115 S. Centre st., S. Orange (7)
Crecca, William D., 111 Park av., Newark (7)
Cregar, John S., 440 S. Harrison st., East Orange(7)
Cremens, John F., 144 Carroll st., Paterson (16)
Crescente, Fred J., 836 Madison av., Paterson (16)
Cricco, Carl F., 909 Washington st., Hoboken (9)
Crist, Walter A., 211 N. Fifth st., Camden (4)
Cronin, Francis J., 730 South st., Elizabeth (20)
Crossfield, Henry C., 144 Harrison st., E. Orange(7)
Crounse, David R., 84 Broadway, Passaic (16)
Crowe, Aldrich C., 735 Atlantic av., Ocean City (5)
Crowley, Joseph W., 4005 Westfield av., Camden (4)
Crunden, Allan B., Jr., 21 Plymouth st., Montclair(7)
Cryder, Millard C., 109 Mechanic av.,CapeM.Ct.H.(5)
Crystell, Edward H., 4 Hawthorne av., Nutley (7)
Ctibor, Vladimir F., Califon (10)
Cucinella, Anthony B., 361 Lafayette st., Newark(7)
Cuddihy, Kathleen, 2023 Center av., Fort Lee (2)
Cummins, Ella F., 39 Elm st., Morristown (14)
Cunningham, Charles, Jr., 716 Wood st., Vinel'd (6)
Cunningham, Joel B., 801 Cooper st., Camden (4)
Cuono, Joseph D., Essex Co. Sana., Verona (7)
Cupaiuoli, Richard A., 30 Lenox pl., Maplewood (7)
Curry, Marcus A., N. J. State Hosp., Greyst'e P.(14)
Curtis, A. Maurice, 445 Van Houten st.,Paterson(16)
Cutler, Milton, 554 Bellevue av., Hammonton (1)
Cziraky, Anton, 516 34th st., Union City (9)

ASSOCIATE MEMBERS

Calabrese, Angelo, 210 Littleton av., Newark (7)
Cano, Harold V., 391 Main st., Spotswood (12)
Carnecchia, Baldo M., 429 Piaget av., Clifton (16)
Castiglia, Peter, 114 Valley rd., Clifton (16)
Chandler, Jennie S., 56 College rd., Princeton (11)
Chase, William M., 84 Astor st., Newark (7)
Clark, John J., 517 Broadway, Long Branch (13)
Cohn, Perry, 234 Lexington av., Passaic (16)
Coleman, William H., 140 Roxboro rd., Trenton (11)
Cortelyou, Thomas P.,83 E. Prospect st.,Hopew'l(11)
Cutler, Paul, 1616 Pacific av., Atlantic City (1)
Cytowic, Edmund R., 883 Brunsw'k av., Trenton(11)

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ACTIVE MEMBERS

D'Acierno, Pellegrino A., 1708 Palis'e av.,UnionC.(9)
D'Addario, Anthony R., 132 Broadway, Newark (7)
D'Agati, Vincent, 955 Queen Anne rd., Teaneck (2)
D'Agostin, Henry, 243 Fulton ter., Cliffside Pk. (2)
D'Agostini, Alfred J., 41 Columbia av., Newark (7)
D'Agostini, Robert J., 41 Columbia av., Newark (7)
Dailey, Edward S., 141 Connett pl., S. Orange (7)
Dalberg, Walter, 500 Cherry st., Elizabeth (20)
D'Alessandro, Arthur J., 15 Salem st., Newark (7)
D'Alessandro, Genesio L., Army (7)
Dallio, Salvatore V., 463 Passaic av., Lodi (2)
Dalton, S. Eugene, 101 S. Surrey av., Ventnor (1)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Daly, John F., 16 N. Brae Court, Tenafly (2)
D'Amato, Charles R., 324 Hoboken rd.,E.Ruth'rf'd(2)
D'Ambola, Philip R., 21 S. Sixth st., Harrison (7)
D'Amico, Thomas V., 70 Fairview av., Verona (7)
Dana, Edward, 163 Prospect av., Hackensack (2)
Dandois, George F., 220 E. Wildwood av., Wildw'd(5)
Dane, Charles, 163 Kilburn pl., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
D'Angelo, Joseph C., 334 Washington av., Bellev'e(7)

Danielson, John J., 4703 Tonnele av., N. Bergen (9)
Dann, Frederick J., 65 Girard pl., Newark (7)
Dante, Pasquale, 393 Millburn av., Millburn (7)
Danzis, Louis, 863 S. 12th st., Newark (7)
Danzis, Maximillian, 31 Lincoln Park, Newark (7)
Darden, Walter T., 149 W. Kinney st., Newark (7)
Darlington, Charles G., 802 Belvidere av., Pl'nf'd(20)
Daron, Simeon, 31 Lincoln Park, Newark (7)
Davenport, Irwin P., 545 W. State st., Trenton (11)
Daversa, Benjamin, 209 Passaic av., Spring L. (13)
David, Leopold S., 326 Cooper st., Camden (4)
Davidson, E. Norwell, 102 East Elm st., Linden (20)
Davidson, Eric W., 290 Park st., Up. Montclair (7)
Davidson, Harold S., 117 S. Illinois av., Atl. City (1)
Davidson, Henry A., R. D. 2, Flemington (10)
Davidson, Maurice M., 128 Grant av.,E.,Roselle P.(7)
Davies, George A., 53 Front st., Elmer (6)
Davies, George W., 35 Fairview av., Verona (7)
Davis, A. Hobson, Paterson Gen. Hosp., Pat'rs'n(16)
Davis, Albert B., 511 Cooper st., Camden (4)
Davis, E. Vernon, 306 E. Main st., Moorestown (3)
Davis, F. Cleveland, 129 Summit av., Summit (20)
Davis, Harold, 170 S. Wash'gton av., Bergenf'd (2)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, J. Stannard, 55 Kings Hgwy.,E.,Had'nf'd(4)
Davis, Jacob M., 1400 High st., Burlington (3)
Davis, John, 10 Washington st., Bloomfield (7)
Davis, Louis, 825 S. Tenth st., Newark (7)
Davis, Stanton H., 212 E. Seventh st., Plainfield (20)
Davis, Thomas C., 30 Old Short Hills rd., Millb'n(7)
Davis, William A., 270 Ridgewood av., Glen Ridge(7)
Davis, William J., 144 Harrison st., East Orange (7)
Davison, C. Spencer, 7 Chestnut st., Salem (17)
Davison, Wilbur S., 13 N. Broadway, Pennsville (17)
Dawson, Harry, 618 E. 24th st., Paterson (16)
Day, Hayward F., 92 Duer st., North Plainfield (18)
Day, Kenneth L., 14 Elm st., Morristown (14)
Day, Samuel T., Main st., Port Norris (6)
Day, Willis B., 407 E. Seventh st., Plainfield (20)
Dear, Abraham L., 23 Synott pl., Newark (7)
DeBell, Peter J., 65 Summer st., Passaic (16)
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford(2)
deBlois, Joseph A.,Jr.,1008 Hamilton av.,Trent'n(11)
DeCecio, Thomas, 691 Palisade av., Cliffside Pk. (2)
DeCesare, Ferdinand J., 500 Walnut st.,RoselleP.(20)
Decker, Charles T., 275 Orchard st., Westfield (20)
Decker, Henry B., 527 Penn st., Camden (4)
DeDominicis, Frank A., 116 17th av., Paterson(16)
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth (20)
DeFelice, Mario T., 790 E. Clarke pl., Orange (14)
DeFilippis, Ralph L., 228 Tremont av., Orange (7)
DeFronzo, Morando, 180 Fairmount av., Newark (7)
DeFuccio, Charles P., 12 Duncan av., Jersey City(9)
DeFusco, G. Thomas, 330 Newark av., Jersey City(9)
Degenhardt, Ira H., 114 S. First st., Highland P.(12)
DeGerome, James H., 10 Ridgewood av., G. Ridge (7)
DeGrace, Francis H., 311 Paulison av., Passaic (16)
DeGregorio, Peter J., 56 Prospect st., Madison (14)
DeHart, George K., 132 Sunset av., Verona (7)
deHellebranth, Roland T.,104 S.Fr'nkf't av.,V'tn'r(1)
Deibert, Irvin E., 538 Cooper st., Camden (4)
Deich, Samuel R., 170 Passaic av., Passaic (16)
Deichman, Charles H., 39 Elm st., Morristown (14)
Deignan, William L., 257 Dodd st., East Orange (7)
Deitmaring, Francis A., 7922 Boulevard,N.Berg'n(9)
Deitz, Joseph R., 915 W. State st., Trenton (11)
Delafrange, Kenneth M.,96Wash'gt'n av.,Westw'd(2)
Delario, Anthony J., 316 Broadway, Paterson (16)
Delatusch, George A., 180 Park st., Montclair (7)
DelBaglivo, Mario, 266 Newark av., Jersey City (9)
Delcau, Jules, 56 W. Main st., Freehold (13)
Delcau, Marie, 123 Main st., South River (12)
Del Deo, Nicholas V., 49 State st., Newark (7)
Del Duca, Vincent P., 514 Cooper st., Camden (4)
DeLeonardis, James V., 94 Jefferson st., Newark (7)
Del Guercio, Olindo, 342 Clifton av., Newark (7)
DeLia, Emilio, 25 Crane st., Newark (7)
D'Elia, William J., 1100 Third av., Spring Lake (13)
Della Penna, Samuel J., 320 Ramapo av.,P'pt'nL.(16)
Della Ragione, Mario, 120 Second av., Newark (7)
Del Mauro, Alphonse, 460 Park av., Paterson (16)
Del Negro, Albert E., 402 Roseville av., Newark (7)
DeLorenzo, Francis, 281 Bellevue av., Montclair (7)
DeLuca, Louis, 323 E. Ridgewood av., Ridgew'd(2)
DeLuccia, Ralph L., 428 Park av., Paterson (16)
DeMarco, Silverino V., 2780 Boulevard, Jer. City (9)
Demaree, Richard H., 310 Norw'd av.,W.L.Br'ch(13)
Demarest, Gerald B., 505 E. Broad st., Westfield(20)
DeMattia, Michael, 71 Ward st., Paterson (16)
DeMichele, Roland V., 516 Clifton av., Newark (7)
Demy, Nicholas G., 912 Prospect av., Plainfield(20)
Denbo, Elic A., 596 Benson st., Camden (4)
Denelsbeck, J. Otis, 878 E. State st., Trenton (11)
Denes, Oscar, 402 Centre st., Nutley (7)
Dengler, Henry P., 260 Morris av., Springfield (20)
Dengrove, Edward, 314 Grassmere av.,Interl'k'n(13)
Denholm, John S., 1048 Coolidge rd., Elizabeth (20)
Denison, Ward C., 316 Broadway, Paterson (16)
Dennison, Alfred D., Jr., 601 Ridgew'd rd.,Map'w'd(7)
DePhillips, Benedict R.,297 Mt. Prosp't av.,New'k(7)
DePietro, Vincent P., 520 48th st., Union City (9)
dePons, Sarah C., 501 Grand av., Asbury Park(13)
DeRosa, Armand, 262 Totowa rd., Totowa (16)
Dershewitz, Irving, 835 Montgomery st., Jer. City(9)
DeSantis, Orazio J., 131 N. Third st., Millville (6)
DeSanto, Anthony M., 377 Essex st., Hackensack(2)
De Simone, Louis E., 1110 Grand av., Asbury P.(13)
Desmet, Victor F., 324 Broadway, Paterson (16)
Detrano, Salvatore J., 903 Wash'gton st.,Hoboken(9)
DeTroia, Frederick C., 26 Stanley rd., S. Orange (7)
Deuell, William D., 190 Elm av., Hackensack (2)
Deutel, Oscar R., 265 Newark av., Bloomfield (7)
Deutsch, Nathan S., 223 E. Fifth st., Plainfield (20)
DeVincentis, Henry, 285 Henry st., Orange (7)
DeVincenzo, F. Richard, 629Wash'gt'n st.,Hob'k'n(9)
DeVita, Anthony J., Wilson av., P. Monmouth (13)
Devlin, Arthur D., 138 Isabella av., Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
deVries, John K., 144 Harrison st., East Orange (7)
Dewis, Edwin G., 21 Westra st., Interlaken (7)
De Yoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Charles N., Jr., 210 Main st., Hackensack (2)
Diamond, David I., Oceanport av., Oceanport (13)
Diamond, J. George, 512 W. Front st., Plainfield(20)
Dickensheets, Jas. G., 4405 Westf'd av., Pen'k'n (4)
Dicker, Ralph L., 31 Lincoln Park, Newark (7)
Dickson, John D., 202 Larch av., Bogota (2)
Dickson, T. Bruce, 408 Main st., Riverton (3)
Diefendorf, Herbert W., 129 Summit av.,Summit(20)
Dieffenbach, Richard H., 570 Mt.Prosp't av.,New'k(7)
Dieker, Howard E., 78 Main st., South River (12)
Diener, Samuel, 14 Clinton pl., Newark (7)
Dierwechter, Reuben, 12 N. Providence av.,Atl.C.(1)
DiFino, Felix J., 172 Edison pl., Newark (7)
DiGiacomo, Harry E., 195 Hunterdon st., New'k(7)
DiGiacomo, William H., 223 Fairm'nt av.,Newark(7)
DiIelsi, Anthony J., 1013 S. Fifth st., Camden (4)
DiLeo, Victor, 453 Park av., Orange (7)
Dilger, Frederick G., 210 Main st., Hackensack (2)
DiMarino, Anthony J., 735 Delaware st.,Paulsboro(8)
Dimitrow, Helen, 236 Broad st., Red Bank (13)
D'Imperio, Francesco, 411 Cooper st., Camden (4)
Dimun, John T., 1000 S. Broad st., Trenton (11)
Dinge, Ferdinand C., 67 S. Munn av., E. Orange (7)
Dingman, Norman M., 330 Broadway, Paterson (16)
DiNicolantonio, Vincent J., 3121 Atl'tic av.,Atl.C.(1)
Dinneen, James B., 503 Park av., Plainfield (20)
DiNorcia, Joseph, 498 W. Market st., Newark (7)
Dintenfass, Arthur, 1616 Pacific av., Atlantic C. (1)
Dirdack, Morris, 12 James st., Morristown (14)

Dirr, John P., 785 Main av., Clifton (16)
Diskan, Samuel M., 1616 Pacific av., Atlantic C. (1)
Dmytriw, Stephen, 226 N. Park st., East Orange (7)
Dodd, William E.,Ocean st.& Bay av.,B'ch Hav'n(15)
Doggett, E. Hugh, 805 Park av., Plainfield (20)
Doherty, William, 830 N. Wood av., Linden (20)
Doktor, David, 648 14th av., Paterson (16)
Dolan, Gerald J., 247 Washington av., Hillsdale (2)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Dolin, Joseph, 357 Woodbridge av., N. Brunsw'k(12)
Dolsky, Irving, 509 N. Wood av., Linden (20)
Donauer, Robert M., 34 Bedford rd., Summit (20)
Donchi, Sol M., 118 Oakview av., Maplewood (7)
Donnelly, John H., 634 S. 20th st., Newark (7)
Donnelly, Joseph E., 445 Market st., Paterson (16)
Donnelly, Joseph P., 58 Kensington av., Jer. City(9)
Donohoe, Lucius F., 140 W. Eighth st., Bayonne (9)
Donovan, Joseph, N. J. State Hosp., Greyst'e P. (14)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doranz, Harold K., 502 W. State st., Trenton (11)
Dorkin, Jerome R., 2908 Federal st., Camden (4)
Dorr, Henry B., 1480 Ocean av., Sea Bright (13)
Dougherty, Daniel D., 1218 Bl'mf'd st., Hoboken(9)
Douglass, Frederick W., 160 Lincoln st., Montc'r(7)
Douglass, William C., 15 Olcott av., Bernardsv'e(18)
Downing, Perley E., N. J. State Hosp., Trenton (12)
Downs, Louis S., 164 Pershing av., Carteret (12)
Doyle, John J., 426 Fairmount av., Jersey City (9)
Drake, Daniel E., Union Valley rd., Newf'dland(16)
Drake, Leo B., 47 Main st., Franklin (19)
Drake, Paul F., 85 Summit av., Phillipsburg (21)
Drake, Willard M., Jr., 406 Cooper st., Camden (4)
Dranow, Paul, 233 Franklin av., Nutley (7)
Drapkin, Berta. 31 Lincoln Park, Newark (7)
Dreizin, David, 201 Lyons av., Newark (7)
Dren, George W., 191 Lexington av., Passaic (16)
Dresel, Irmgard, Mine Brook rd., Far Hills (18)
Dreskin, Jacob L., 34 Lyons av., Newark (7)
Dresner, Evelyn E., 190 Park st., Ridgefield P. (2)
Drewniany, Bernardine, 461 Kingsland av.,L'dh'st(7)
Drews, Francis F., Jr., 530 Broad av., Englew'd (2)
Drezner, Henry L., 216 W. State st., Trenton (11)
Driggs, Marshall F., 242 Engle st., Englewood (2)
Driscoll, Charles D., 475Wt.HorsePk.,W.Col'gsw'd(4)
Driscoll, Raymond S., 117 W. Fifth st., Bayonne (9)
Drossner, Jacob L., 1300 Park Blvd., Camden (4)
duBusc, L. C. Victor, 399 Westfield av.,Elizabeth(20)
Dudley, Henry G., 222 Sylvania pl., Westfield (20)
Duffy, Edward P., Jr., 379 Wash'gton av.,Bellev'e(7)
Duffy, William J., 22 Nairn pl., Newark (7)
Dukes, Howard R., 220 Kearny av., Kearny (9)
Dul, Emil J., 154 Plauderville av., Garfield (2)
Dulany, Theodore L., 170 W. Market st., Newark (7)
Dulin, Everett V., 144 Harrison st., East Orange(7)
Duncan, Owsley B., 414 Ellison st., Paterson (16)
Dunham, Malcolm M., 88 Grove av., Woodbridge(12)
Dunn, H. Irving, 610 Salem av., Elizabeth (20)
Dunn, John S., 75 Market st., Salem (17)
Dunn, Theodore B., 35 Park pl., Bloomfield (7)
Dupuy, Jean G., 850 Jersey av., Elizabeth (20)
Durchlag, E. Nelson, 60 Myrtle av., Irvington (7)
Durham, Frederick W.,20 KingsHwy.,W.,Had'nf'd(4)
Durham, Robert B., 110 S. N. Carolina av., Atl. C.(1)
Durham, Royal E., 100 S. New Haven av.,Ventnor(1)
Durrah, Fred F., 310 Plainfield av., Plainfield (20)
Duschock, Edward F., 473 Amboy av., P. Amboy(12)
Duvall, Albert I., Broad st., Shrewsbury (13)
Dwork, Harold K., 1 Hansbury av., Newark (7)
Dwoyer, Leon C., 420 N. Wood av., Linden (20)
Dwulet, Leon, 910 Arnold av., Point Pleasant (15)
Dwyer, Gregory, Community Med. Gr., Boonton(14)
Dwyer, Henry E., 261 Madison st., Passaic (16)
Dwyer, William A., 99 Park av., Paterson (16)
Dyer, Edward H., 102 S. Victoria av., Ventnor (1)

ASSOCIATE MEMBERS

DeRosa, Vincent A., 31 Oakwood av., L. Branch (13)
DeVito, Alfred T., 405 La Reine av., Bradley B. (13)
DeVries, Peter J., 180 Carroll st., Paterson (16)
Diamond, Paul, 372 Fairview av., Westwood (2)
Doggett, Frank B.,Jr., 124 North Ohio av.,Atl.City(1)
Dooley, James H., 295 Montgomery st., Bloomf'd (7)

E

ACTIVE MEMBERS

Eames, William N., 1871 Pennington rd.,Trenton(11)
Earp, Ruth, 15 Olcott av., Bernardsville (14)
Eason, Samuel W., 48 De Forest av., Summit (20)
Ebenfeld, Samuel W., 344 High st., Newark (7)
Ebner, Paul G., 408 Overhill rd., Haddonfield (4)
Echikson, Joseph I., 31 Lincoln Park, Newark (7)
Eck, Daniel B., 144 Harrison st., East Orange (7)
Ecker, Joseph L., Clinton (10)
Eckert, Walter L., 11532 Dilling st., N.Hollyw'd,C.(1)
Eckhardt, Janet L., 120 Prospect st., S. Orange (7)
Eckhardt, Ralph A., 50 Green Vil. rd.,Madison(14)
Eckstein, David, 407 Greenwood av., Trenton (11)
Eddy, Lester R., 40 Bank st., Sussex (19)
Edelberg, Sidney S., 403 E. High st., Bd. Brook(18)
Edelen, James J., 100 S. Munn av., East Orange (7)
Edelson, Edmond, 127 Lehigh av., Newark (7)
Edelson, Samuel, 1611 Grand av., Asbury Park (13)
Edelstein, Isidore, 938 Hudson st., Hoboken (9)
Edgar, Malcolm S., 129 Summit av., Summit (20)
Edgerly, Sherburn E., 220 Engle av., Englewood (2)
Edikraut, Edward C., 320 Lexington av., Clifton(16)
Edson, James, 336 Belmont av., Haledon (16)
Edwards, J. Bennett, 144 Woodridge pl., Leonia (2)
Edwards, Sydney K., 52 Lexington dr.,Livingston(7)
Edwards, Walter R., 2624 Quaker Br.rd.,M're'rv'e(11)
Ehrenfeld, Edward, 185 Lexington av., Passaic (16)
Ehrenfeld, Irving, 185 Lexington av., Passaic (16)
Ehrlich, Edward, 838 S. 13th st., Newark (7)
Ehrlich, Max, 721 N. Broad st., Elizabeth (20)
Ehrlich, William E., 31 Lincoln Park, Newark (7)
Ehrlich-Morrow, Laura E.,197 Passaic av.,Pass'c(16)
Eichler, Bernard B., 221 Midland av., Montclair (7)
Ein, William B., 31 Lincoln Park, Newark (7)
Einhorn, Harvey, 241 16th av., Newark (7)
Einhorn, Samuel E., 241 16th av., Newark (7)
Eisemann, Jerome S., 38 Main st., Butler (16)
Eisenberg, David S., 31 Lincoln Park, Newark (7)
Eisenhower, J. S. D., 2704 Pacific av., Wildwood (5)
Eisenstodt, Lester W., 31 Lincoln Park, Newark(7)
Elias, Elmer J., 474 Greenwood av., Trenton (11)
Ellenbogen, Leonard S., 1616 Pacific av.,Atl.City(1)
Ellenson, Solomon S., 507 Fourth av., Asbury P.(13)

Elliott, Frazier J., 10 N. Second st., Hammonton(1)
Ellis, Alexander, 519 Broadway, Camden (4)
Ellis Arthur J., 140 Roseville av., Newark (7)
Ellis, Ralph W., 64 Fairview av., Morrisville,Pa.(11)
Ellmers, Basil J., 304 Milford av., New Milford (2)
Elwell, Alfred M., Jr., 149 E. Main st., Moorest'n(3)
Elwell, Robert W., 215 Center av., Delanco (3)
Elwood, Benjamin J., 91 W. 38th st., Bayonne (9)
Ely, Lancelot, 128 W. High st., Somerville (18)
Emmer, S. Wolfe, 31 Lincoln Park, Newark (7)
Emory, George B., Jr., 1 Franklin pl.,Morristown(14)
Engelhart, Ferdinand K., 28 Oak lane, Trenton (11)
English, Harrison F., III, 160 W.State st.,Trent'n(11)
English, John T., 110 Yale av., Irvington (7)
Epstein, Harry B., 31 Lincoln Park, Newark (7)
Epstein, William M., 322 E. Westfield av.,Ros'leP.(7)
Erber, Leonard B., 1902 Pacific av., Atlantic City(1)
Erdman, George L., 50 Cedar st., Maplewood (7)
Erler, Robert E., 360 Prospect st., S. Orange (7)
Ernest, Richard B., 240 W. State st., Trenton (11)
Ernst, Philip A., 16 E. Main st., Mays Landing (1)
Ervin, Millard B., 36 Canterbury lane, Westfield(7)
Esposito, Amedeo C., N.J. State Hosp.,Gr'yst'eP.(14)
Esposito, Anthony L., 246 Lexington av., Passaic(16)
Esposito, Antonio L., 31 12th st., Hammonton (1)
Essertier, Edward P., 275 State st., Hackensack (2)
Essertier, Harland C., 263 Franklin av., Ridgew'd(2)
Esty, Geoffrey W., 629 E. Broad st., Westfield (20)
Etheridge, Charles H., 433 Prospect st., E. Orange(7)
Ettinger, Samuel, 501 32nd st., Union City (9)
Evans, Charles H., 144 Harrison st., E. Orange (7)
Evans, David P., 144 Harrison st., East Orange (7)
Evans, Edgar E., 12 Ziegler Tract, Penns Grove (17)
Evans, Edgar J., 25 Second av., Denville (14)
Evans, J. Lawrence, 7117 Park av., Woodcliff (9)
Evans, J. Lawrence,Jr.,254 Christie Hts.st.,Leonia(2)
Evans, John R., Jr., 496 Prospect st., Maplewood(7)
Ewens, Arthur E., 3600 Pacific av., Atlantic City(1)
Ewing, Harvey M., 31 Trinity pl., Montclair (7)
Ewing, Leslie H., 10 Broad st., Berlin (4)
Eynon, Harold K., 538 Cooper st., Camden (4)
Eynon, James R., 20 E. Knight av., Collingswood(4)

ASSOCIATE MEMBERS

Eccleston, Herbert H., 124 Elm av., Hackensack (2)
Effron, Samuel A., 666 Broadway, Paterson (16)
Eisenstein, Bernard, 276 Engle st., Englewood (2)
Ellis, William C., 69 W. Front st., Red Bank (13)
Estrin, Seymour S., 300 Main st., Bradley Beach(13)
Evans, H. Walter, Jr.,Fitkin Mem.Hosp.,Nept'ne(13)

F

ACTIVE MEMBERS

Faber, Edward, 154 Bergen av., Jersey City (9)
Fabian, Paul L., 520 Princeton av., Trenton (11)
Fabriele, John B., 977 Avenue C, Bayonne (9)
Facciolo, Frank, 562 Boulevard, Bayonne (9)
Fadden, Francis J., Jr., 275 Engle st., Englewood (2)
Fader, Ferdinand, 350 Springdale av., E. Orange (7)
Fager, Rudolph O., 53 Park pl., Bloomfield (7)
Fahrenbruch, Freder'k D.,101 Garden st.,Mt.Holly(3)
Failing, Brayton E., 31 Lincoln Park, Newark (7)
Failmezger, Theodore R., 125 Green av., Madison(14)
Fain, Irving, 155 Chancellor av., Newark (7)
Faison, John B., 45 Glenwood av., Jersey City (9)
Falcone, Albert M., 502 E. Broad st., Westfield (20)
Falcone, Nicholas A.,68Watchung av.,N.Plainf'd(18)
Falvello, Nicholas A.,P.O. Box 122,Deerf'd B.,Fla.(14)
Fanelli, Antonio, 494 Compton av., Perth Amboy(12)
Faraci, Charles, 23 Diamond Spring rd.,Denv'le(14)
Farb, Harry H., 21 Clinton pl., Newark (7)
Farber, Herbert R., 675 Broadway, Paterson (16)
Farkas, Gustav, 255 Harrison st., Passaic (16)
Farmer, Vincent, 430 Union st., Hackensack (2)
Farmer, Walter D., 28 S. Main st., Allentown (11)
Farr, Walter J., 955 Queen Anne rd., Teaneck (2)
Farrell, Edgar A. H., 26 Kings Hwy.,W.,Had'nf'd(4)
Fasano, Giovanni, 194 S. Seventh st., Newark (7)
Fath, Marcus A., 108 E. Glenwood av., Wildw'd(5)
Fattel, Henry C., 8300 Boulevard, N. Bergen (9)
Faulkingham, Ralph J.,61Liv'st'n av.,N.Br'nsw'k(12)
Faux, Freder'k J., 32 N. Columbia st., Woodb'y(8)
Fava, Philip V., 646 Sanford av., Newark (7)
Fazio, Vincent J., 227 Augusta st., S. Amboy (12)
Featherston, Daniel F., 601 Grand av., Asbury P.(13)
Fechner, Julius, 362 Clinton av., Newark (7)
Federer, John J., 69 Columbia ter., Weehawken (9)
Fedor, John A., 969 S. Broad st., Trenton (11)
Feher, Ladislas A.M.,177 Somerset st.,N.Br'sw'k(12)
Fein, Bernard, 585 Elizabeth av., Newark (7)
Feinberg, Harry D., 384 Second av., L. Branch (13)
Feinsod, Samuel N., 1305 Clinton av., Irvington (7)
Feinstein, Louis, 410 Pacific av., Atlantic City (1)
Felder, Samuel, 221 Main st., Flemington (10)
Feldman, Frank H., 115 Lyons av., Newark (7)
Feldman, Joel, 64 West Front st., Red Bank (13)
Feldman, Morris, 51 Bentley av., Jersey City (9)
Feliciano, Vincent, 286 Lafayette av.,Hawthorne(16)
Felitti, Vincent J., 435 79th st., N. Bergen (9)
Feller, William, 283 Bergen av., Jersey City (9)
Feman, J. George, 141 Main st., Keansburg (13)
Fendrick, Edward, 17 Watson av., East Orange (7)
Fenimore, Edward D., 77 Grace st., Jersey City (9)
Fenster, Morton N., 202 Lexington av., Passaic(16)
Fenton, Tennant E., 320 Ludlow av., Spring L. (13)
Fenwick, John R., 196 Lakeview av., Clifton (16)
Ferenchak, Ralph, 219 Martine av.,N.,Fanwood (20)
Ferguson, John, Mon. Mem. Hosp., L. Branch (13)
Ferguson, William E., Newark City Hosp., New'k(7)
Fermaglich, Harry B., 881 Garrison av., Teaneck(2)
Fern, Samuel S., 122 Elizabeth av., Newark (7)
Fernicola, Anthony R., 565 Mt. Prosp't av.,New'k(7)
Ferrante, Joseph, 803 Prospect av., Ridgefield (2)
Ferrari, Andrew F., 196 Main st., E. Rutherford (2)
Ferrari, Salvatore, 372 21st av., Paterson (16)
Ferrary, Paul B., 80 Park av., Paterson (16)
Ferris, Ruth B., 8 Wetmore av., Morristown (14)
Fessler, A. James, 1544 S. Broad st., Trenton (11)
Fessler, William, 31 Knox av., Cliffside (2)
Fessman, John W., 114 Clements Br. rd.,Run'm'de(4)
Feuer, Joseph A., 59 Seeley av., Arlington (7)
Fialk, Harry, 337 52nd st., West New York (9)
Ficke. Sylvia A., 906 Summit av., Jersey City (9)
Ficker, Robert F., Ogdensburg (19)
Fidler, Jay W., Jr., 1441 Hazelwood ter.,Plainf'd (20)
Fidler, William L., III, Brace rd., Haddonfield (4)
Fiedler, Michael J., 2368 S. W. 4th st.,Miami,Fla.(20)
Field, Frank L., Far Hills (18)
Fielding, William M., 15 Waldwick av., Waldw'k(16)

Fietti, Vincent G., 112 Ridge rd., Lyndhurst (2)
Fifer, William T., 746 Avenue C., Bayonne (9)
Figliolino, Francis, 272 W. Milton av., Rahway (20)
Filkins, Cedric E., 412 White Horse Pk., Audubon(4)
Filsinger, Carl W., 109 W.Maple av.,Merchantv'le(4)
Finby, Nathaniel, 46 Main st., Netcong (14)
Fine, Hyman P., 151 Market st., Perth Amboy (12)
Fine, Irvin J., 280 Hobart st., Perth Amboy (12)
Finegan, Paul J., 200 W. State st., Trenton (11)
Finger, Frederick A., 943 Avenue C, Bayonne (9)
Fink, A. Elston, 489 High st., Newark (7)
Fink, Irving E., 71 Lincoln Park, Newark (7)
Fink, Stanley J., 221 Chestnut st., Roselle (20)
Finke, Charles H., 317 York st., Jersey City (9)
Finke, Charles H., Jr., 317 York st., Jersey City (9)
Finke, George W., 237 State st., Hackensack (2)
Finke, John H. D., 19 Hudson st., Hackensack (2)
Finkel, Joshua, 853 S. 11th st., Newark (7)
Finkelstein, Aaron, 762 S. Tenth st., Newark (7)
Finkelstein, Abe S., 670 Clinton av., Newark (7)
Finkelstein, Max, 3258 Boulevard, Jersey City (9)
Finkle, Lester J., 495 W. State st., Trenton (11)
Finkler, Rita S., 35 Leslie st., Newark (7)
Finn, Henry R. W., 84 Lembeck av., Jersey City (9)
Finnegan, William R., Box 191, R.F.D. 5, Nixon(12)
Finnerty, Urban R., St. Vincent's Hosp.,Montcl'r(7)
Fiorello, Joseph R., 689 Princeton av., Trenton (11)
Fioretti, Ralph J., 315 Rochelle av., Rochelle Pk. (2)
Fischbein, Martin M., 976 Sanford av., Irvington(7)
Fischer, David D., 35 Goldsmith av., Newark (7)
Fischer, Leo E., 70 Sherman pl., Jersey City (9)
Fischer, Louise, 31 Lincoln Park, Newark (7)
Fischman, Harold H., 326 Avon av., Newark (7)
Fisher, James A., 501 Grand av., Asbury Park (13)
Fisher, Samuel, 808 Madison av., Paterson (16)
Fishkoff, Alexander H., 132 Market st., P.Amboy(12)
Fissell, George M., 140 Roseville av., Newark (7)
Fitch, Thomas S. P., 916 Park av., Plainfield (20)
Fitzgerald, Robert, 32 Johnson av., Newark (7)
Fitzhugh, William F., 190 Euclid av., Ridgef'd P.(2)
Fitzpatrick, Leo J., 541 Churchill rd.,W.Englew'd(2)
Flanagan, James F., 195 Elwood av., Newark (7)
Flanagan, John J., 173 Roseville av., Newark (7)
Flax, Jacob L., 31 Lincoln Park, Newark (7)
Fleischmann, Viola G., 103 Scotland rd., S. Orange(7)
Fleming, Charles L., 42 W. Main st.,PennsGrove(17)
Fleming, Joseph A., 247 Claremont av., Montclair(7)
Flichtenfeld, Morris, 283 Fourth st., Jersey City (9)
Flicker, David J., 82 Clinton av., Newark (7)
Fliegel, Hilda C., 309 Baldwin av., Jersey City (9)
Fliegel, William M., 85 W. Passaic st., Maywood (2)
Flint, Edgar T., 44 E. Somerset st., Raritan (18)
Floody, Robert J., 324 Kingsland st., Nutley (7)
Flower, Morrie A., 39 Lincoln Park, Newark (7)
Fluck, David A., 626 W. State st., Trenton (11)
Fluck, Paul H., 73 N. Union st., Lambertville (10)
Flynn, Edward A., 176 Washington av., Bellev'e (7)
Foley, James F., 344 N. Grove st., East Orange (7)
Foley, James G., Craig st., Basking Ridge (14)
Follette, William J., 375 Engle st., Englewood (2)
Folsome, Clair E., 1075 Central av., Plainfield (20)
Fonda, Gerald E., 6 Parkview dr., Millburn (7)
Foote, Sherman K., Clinton av., Wyckoff (16)
Forer, Robert, 434 Bellevue av., Trenton (11)
Forestiere, Jasper, 10 Park pl., Morristown (14)
Forney, Norman N., 94 N. Main st., Milltown (12)
Forney, Norman N., Jr., Stelle av., Milltown (12)
Forsberg, Roy T., 110 W. Fifth av., Roselle (20)
Fortay, Steven O., 474 Park av., Paterson (16)
Forte, Daniel L., 545 Central av., Orange (7)
Forte, F. Chester, 374 Park st., Hackensack (2)
Forte, Frank S., 318 Roseville av., Newark (7)
Fortuin, Floyd, 434 Park av., Paterson (16)
Fortunato, Joseph F., 349 Walnut st., Newark (7)
Fortunato, Samuel J., 90 Kenwood pl., E. Orange (7)
Fost, William H., 107 Franklin st., Belleville (7)
Foster, Frank L., 320 Springfield av., Cranford (20)
Fowler, Royale H., 744 Broad st., Newark (7)
Fox, Wm. W., 101 S. Indiana av., Atlantic City (1)
Frame, Dorothy L., 15 Highland av., Glen Ridge (7)
Francy, Donald G., 314 Stuyvesant av., Lyndhurst(7)
Frank, Geza M., 56 Hedden ter., Newark (7)
Frank, Herman I., 98 W. 35th st., Bayonne (9)
Frank, Morris, 920 Avenue C, Bayonne (9)
Frank, Myrtile, 227 Philadelphia av., Egg Harbor(1)
Frank, Nathan, 180 Bowers st., Jersey City (9)
Frank, Perry, 227 Philadelphia av., Egg Harbor (1)
Frank, Simon C., 62 Ridge rd., North Arlington (7)
Frank, Ulysses M., 12 Undercliff rd., Millburn (7)
Frankel, Henry, 229 60th st., West New York (9)
Frankel, Theodore H., 600 Crescent av., Pl'nf'd(20)
Franklin, Charles M., 56 Elm rd., Princeton (11)
Franklin, Frank A., 256 S. Centre st., Orange (7)
Franklin, I. Harold, 191 Palisade av., Jersey City(9)
Franklin, Joseph E., 191 North av., Hillside (20)
Franklin, Lewis J., 149 Jean ter., Union (20)
Frantz, Max K., 624 S. Fifth st., Camden (4)
Franzoni, Andrew E., 938 Brunsw'k av.,Trent'n(11)
Fratantuno, Michael J., 14 Vermont av., Newark(7)
Fraulo, Louis, 241 Crooks av., Clifton (16)
Frazee, William H., Jr.,Chambers W.H.,Penns G.(17)
Frederick, George F., 179 Main st., Woodbridge (12)
Freedman, Harold H., 63 W. Main st., Freehold (13)
Freedman, Jacob S., 178 Hamilton av., Passaic (16)
Freeman, George C., Prudential Ins. Co., Newark(7)
Freeman, Ray M., 2011 St. Georges av., Rahway (20)
Freeman, William S., 117 N. Third av.,Highl'd P.(12)
Freinkel, Jacob, 2 Hillside av., Newark (7)
Freund, Seelig, 617 W. State st., Trenton (11)
Freyberger, George A., 85 Columbia ter.,Weeh'k'n(9)
Freymann, Walter, 5006 Hudson av., W. N. Y. (9)
Fridrich, Harry E., 4172 Federal st., Camden (4)
Friedenberg, Sidney, 2990 Alabama rd., Camden (4)
Friedenthal, Bernard, 88 Liv'gst'n av.,N.Br'sw'k(12)
Friedland, Arnold J., 200 N. East av., Vineland (6)
Friedlander, Erwin W.,213Westfield av.,Elizab'h(20)
Friedman, Abraham I., 405 State st., Hackensack(2)
Friedman, Edna C., 732 E. 26th st., Paterson (16)
Friedman, Harry, 721 S. 16th st., Newark (7)
Friedman, Hyman, 1096 Sanford av., Irvington (7)
Friedman, Max, 849 W. State st., Trenton (11)
Friedman, Meyer H., 949 W. State st., Trenton (11)
Friedmann, Gustav, 425 Park av., Paterson (16)
Friedmann, Leonard L., 484 Princeton av.,Tr't'n(11)
Friedrich, Adam H., 47 Clark st., Manasquan (7)
Friery, John F., 297 S. Wash'gton av.,Berg'nf'd (2)
Fritts, Lewis C., 118 West End av., Somerville (18)
Fritz, John F., Jr., 95 Main st., Flemington (10)
Froelich, Jerome J., 74 Ingraham pl., Newark (7)
Froelich, Joseph C., 74 Ingraham pl., Newark (7)
Frohwein, Ida H., 125 Morristown rd., Elizabeth (20)
Fromkin, Charles, 20 Bank st., Bridgeton (6)
Frosch, Frank J., 1423 Pennington rd.,Trenton(11)
Fruchtbaum, Robert P., 431 Franklin av., Nutley (7)
Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
Fuhrmann, Barclay S., 10 Main st., Flemington (10)
Fuhrmann, John B., 10 Main st., Flemington (10)
Fullerton, Harry W., Jr., 86 Shell rd.,Penns Gr.(17)
Fullilove, Robert E., Jr., 24 Waverly av., Newark (7)
Furey, Joseph A., 224 E. Wildwood av., Wildw'd(5)
Furman, Benjamin A., 31 Roseville av., Newark (7)
Furman, Sol T., 344 Fairmount av., Jersey City (9)
Furst, Nathan J., 299 Clinton av., Newark (7)
Furst, William, 188 Clinton av., Newark (7)

ASSOCIATE MEMBERS

Fares, Louis G., 471 Centre st., Trenton (11)
Farley, William, 17 Elwood pl., Newark (7)
Fasanella, Rocco, P.O. Box 1001, N. Haven, Conn.(11)
Fisher, James A., Jr., 601 Grand av., Asbury P. (13)
Fonda, Donald A., 417 Getty av., Paterson (16)
Friedland, Walter, 210 Main st., Hackensack (2)

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ACTIVE MEMBERS

Gadek, Stanley A., 95 Fayette st., Perth Amboy (12)
Gadomski, Casimir F., 331 S. Broad st., Elizabeth(20)
Galgoczy, Julius, Box 473, Manville (18)
Galioto, Frank M., 188 Ampere Pkwy., Bloomf'd (7)
Gallardo, Agustin, 61 Lakeside av., Pompton L. (16)
Gallaway, George E., 163 W. Milton av., Rahway(20)
Gallo, James S., E. Allendale av., Saddle River (16)
Gamba, Joseph, 388 Fairmount av., Newark (7)
Gambacorta, Leopoldo, 397 N. 13th st., Newark (7)
Gambacorta, Otto, 98 Broad st., Bloomfield (7)
Gambill, Perry J., N. J. State Hosp.,Greyst'neP.(14)
Gamon, Robert S., 514 Cooper st., Camden (4)
Gamsu, George, Army (7)
Ganley, Arthur J., 390 Park av., East Orange (7)
Gannon, John R., Passaic Gen. Hosp., Passaic (16)
Gannon, Joseph M., 149 Crescent av., Plainfield (20)
Ganot, Frank I., 392 Ridge st., Newark (7)
Gantt, Margaret H., 43 Hillcrest rd., Madison (14)
Garbarini, John G., 93 Clifton pl., Jersey City (9)
Garber, Robert S., N. J. State Hosp., Trenton (11)
Gardam, Joseph W., 16 Longfellow av., Newark (7)
Gardner, Kenneth E., 45 Fremont st., Bloomfield (7)
Garnett, Robert, 285 Lexington av., Passaic (16)
Garrison, Sherman, 108 W.Commerce st.,Bridget'n(6)
Gartlan, Bernard W., 405 Main st., Toms River (15)
Garwood, Norman W., Church st., Crosswicks (11)
Gaspar, Istvan A., 407 Warwick av.,W.Englew'd(2)
Gatti, Joseph D., 92 E. Hunter av., Maywood (2)
Gaugier, Louis C., 85 Up. Mountain av., Montcl'r(7)
Gaydos, Albert, 225 Hillside av., Nutley (7)
Gaylor, Earl L., Jr., 85 S. Harrison st., E. Orange(7)
Geannette, Ernest D., 14 Harrison av., Montclair(7)
Geary, Paul, 909 Park av., Plainfield (20)
Gebele, William X.,Jr.,421 Second st.,Lakewood(15)
Gebirtig, Theodore, 181 South st., Morristown (14)
Ged, Archie K., 1133 Main st., Paterson (16)
Gehl, Raymond H., 114 Lyons av., Newark (7)
Gehl, Sidney H., 83 Wolcott ter., Newark (7)
Geib, Margaret E., 1277 Clinton pl., Elizabeth (20)
Geiger, Harold C., Main st., West Milford (16)
Geissler, Elmer E., 327 Monmouth st., Gloucester(4)
Gelb, Jerome, 86 W. Alpine st., Newark (7)
Geller, Joseph J., 137 Ellison st., Paterson (16)
Geller, Samuel, 696 High st., Newark (7)
Gellman, William B., 163 Valley Blvd.,Wood-R'ge(16)
Gelman, Sidney, 600 E. 27th st., Paterson (16)
Gencher, Benjamin, 33 Park av., Caldwell (7)
Gennell, Ernest, 298 Parker st., Newark (7)
Genninger, Lewis E., 95 S. Main st., Phillipsburg(21)
Gentile, Ernest R., 125 Hamilton st., Bd. Brook (18)
George, Amerigo, 153 Third av., Long Branch (13)
George, Melbourne E. W., 744 Broad st., Newark (7)
Gerard, Arpad G., 502 Rahway av., Woodbridge (12)
Gerard, Patrick D., 364 Roseville av., Newark (7)
Gerendasy, Julius, 956 E. Jersey st., Elizabeth (20)
Gerhardt, Paul E., 718 S. 17th st., Newark (7)
Germain, Raymond J., 75 Center st., Clinton (10)
German, Bernard, 89 Lincoln Park, Newark (7)
German, George B., 15 W. Walnut av., Merch'tv'e(4)
Gerne, Timothy A., 972 Summit av., Jersey City (9)
Gershenfeld, David B., 73 Shanley av., Newark (7)
Gershman, Joseph G., 185 E. Madison av.,Dumont(2)
Gerson, Stanley, 480 Park av., Paterson (16)
Gessner, Gerard R., 159 New st., N. Br'nsw'k (12)
Gesswein, Carl A., 35 Church st., Matawan (13)
Gewanter, Aaron P., Somerset Hosp., Somerv'le (18)
Ghee, Euclid P., 115 Claremont av., Jersey City (9)
Giacalone, Vincent, 58 N. Valley av., Vineland (6)
Giacona, Joseph, 221 Lincoln av., Union (20)
Giambra, Sante M., 400 Park av., Paterson (16)
Gian-Grasso, Joseph A.,343 Hamilton av.,Trent'n(11)
Giannasio, Joseph, 813 Montgomery st., Jer. City (9)
Gianni, Angelo R., 37 Main st., Netcong (14)
Giannotto, Anthony S., 403 S. 10th st., Newark (7)
Gianquinto, Peter, St. Barnabas Hosp., Newark (7)
Giardina, John S., 321 Walnut st., Newark (7)
Giardina, Vincent J., 102 Jefferson st., Newark (7)
Gibb, Alice S., 339 Union av., Elizabeth (20)
Gibson, Augustus, Mendham (7)
Giffoniello, Arthur A., 334 Roseville av., Newark (7)
Gifford, William R., 247 Park av., East Orange (7)
Giglio, Alphonsus S. V., 626 Elizab'h av.,Eliz'b'h(20)
Giglio, Louis A., 610 E. 27th st., Paterson (16)
Gilbert, Philip D., 514 Cooper st., Camden (4)
Gilbertson, Robert L., 26 Maple av., Morristown (14)
Gillespie, John L., 26 Midland av., Arlington (7)
Gilman, Leonard, 6 S. Fullerton av., Montclair (7)
Gilpatrick, Charles E., 18 Spring st., PennsGrove(17)
Gilpin, Fletcher, 118 North av., W., Cranford (20)
Gindhart, Floyd D., 1213 Hamilton av., Trenton (11)
Gindhart, John H., 1213 Hamilton av., Trenton (11)
Ginsberg, George, 624 Bloomfield st., Hoboken (9)
Ginsberg, Leon, Essex County Hosp., Cedar Grove(7)
Ginsburg, Samuel, 227 Paulison av., Passaic (16)
Giordano, Salvatore, 13 DeHart st., Morristown (14)
Giordano, William C., 948 Maple av., Ridgefield (2)
Girardo, Anthony J., 22 Taunton av., Berlin (4)
Gitlitz, Abraham J., 54 Joyce rd., Tenafly (9)
Gittelman, Morton, 879 Newark av., Elizabeth (20)
Gittelsohn, Isador, 700 Kinderkam'k rd.,River E.(2)
Gitterman, David A., 519 Engle st., Englewood (2)
Giuffra, Frank, 161 Park st., Montclair (7)
Giuliana, Robert A., 31 Central av., Newark (7)
Glaser, Emanuel, 360 Linden av., Elizabeth (20)
Glass, Benjamin E., 609 Watchung av.,Plainfield(20)
Glass, George A., 282 E. Main st., Somerville (18)
Glass, Harry L., 1009 Park av., Plainfield (20)
Glass, Oscar, 838 S. 12th st., Newark (7)
Glass, William H., 144 Harrison st., East Orange(7)
Glasser, Benjamin F., 32 Lindon av., Highl'd P.(12)
Glazebrook, Francis H., Honeys'kle W'ds,R'ms'n(14)
Glazer, Edward, 84 Richmond pl., Deal (13)
Glazier, Jesse T., 670 Sanford av., Newark (7)
Gleason, Edwin A., 115 Wesley av., Erlton (4)
Gleason, James F., 5407 Atlantic av., Ventnor (1)
Glick, Bernard, 307 Stuyvesant av., Lyndhurst (2)
Glover, Lawrence L.,53 King's Hgwy.W.,Had'nf'd(4)
Gluckman, Saul K., 78 Johnson av., Newark (7)
Glynn, S. Robert, 54 Girard pl., Newark (7)
Gochman, Harry M., 166 Hamilton av., Paterson(16)

Godfrey, Alan O., 231 Roseville av., Newark (7)
Goeller, Jacob D., 1165 W. Clinton av., Irvington (7)
Goffman, Emanuel, 316 Claremont av., Montclair(7)
Goldberg, Benjamin M., 1156 E. State st.,Trent'n(11)
Goldberg, Bernard R., 190 Clinton av., Newark (7)
Goldberg, David, 336 Westwood av., Westwood (2)
Goldberg, Harold H., 814 S. Tenth st., Newark (7)
Goldberg, Harry C., 7 Watchung av., Plainfield (20)
Goldberg, Jacob, 155 Franklin av., Long Branch (13)
Goldberg, Louis E., 31 Lincoln Park, Newark (7)
Goldberg, Samuel A., 169 Gregory av., W. Orange(7)
Golden, Clement H., 30 Myrtle av., Irvington (7)
Golden, William M., 236 W. Milton av., Rahway (20)
Goldenberg, Raphael R., 588 E. 27th st.,Paterson(16)
Goldfarb, Abraham, 52 Chestnut st., Rutherford (2)
Goldfield, Harold H., 225 E. Jersey st., Elizabeth(20)
Golding Harry N., 180 Carroll st., Paterson (16)
Goldmacher, Herman B., 113 Elmora av.,Elizab'h(20)
Goldman, David L., 42 W. 22nd st., Bayonne (9)
Goldman, Jerome, 1 Johnson av., Newark (7)
Goldman, Leo L., 325 Market st., Trenton (11)
Goldman, Lester M., 53 Leslie st., Newark (7)
Goldman, Louis C., 6 N. Austin av., Ventnor (1)
Goldman, Samuel, 414 Cooper st., Camden (4)
Goldman, Solomon, 161 Livingston av.,N.Br'sw'k(12)
Goldsmith, Alfred S., 8129 Boulevard, N. Bergen (9)
Goldstein, Abraham, 404 Madison av., Lakewood(15)
Goldstein, Benjamin, 320 Asbury av., Asbury P. (13)
Goldstein, Edward W., 561 E. 28th st., Paterson (16)
Goldstein, Henry Z., 31 Lincoln Park, Newark (7)
Goldstein, Herman H., 318 W. Jersey st.,Elizab'h(20)
Goldstein, Hyman I., 1425 Broadway, Camden (4)
Goldstein, Samuel, 34 E. Main st., Mays Landing (1)
Goldstein, Samuel M., 40 Johnson av., Newark (7)
Golish, Harry L., 425 15th av., Paterson (16)
Gonczy, Edward J., 420 Jersey av., Elizabeth (20)
Goodman, Harry P.,101 S. Indiana av.,Atlantic C.(1)
Goodman, Kenneth, 141 Park av., East Orange (7)
Goodman, Stanley J., 89 Lincoln Park, Newark (7)
Goodspeed, William K., Oakwood rd., Watch'g(20)
Gordon, A. Julius, 140 Roseville av., Newark (7)
Gordon, Abel, 616 Main av., Passaic (16)
Gordon, Benjamin L., 6917 Atlantic av., Ventnor (1)
Gordon, Charles D., Mt. Arlington (14)
Gordon, J. Berkeley, N. J. State Hosp., Marlboro(13)
Gordon, Maurice B., 6917 Atlantic av., Ventnor (1)
Gordon, Milton H., 12 N. 27th st., Camden (4)
Gordon, Samuel, 540 Park av., Paterson (16)
Gordon, William, 648 Ringwood av., Wanaque (16)
Gorenberg, Harold, 55 Bentley av., Jersey City (9)
Gorman, Robert B., 410 Kinderkamack rd.,Oradell(2)
Gorman, Rosemary, 811 N. Broad st., Elizabeth (20)
Gormley, Cyrus M., 320 Broadway, Paterson (16)
Gorog, Nicholas M., 159 Bayard st., N. Br'sw'k (12)
Gorson, Samuel F., 2005 Pacific av., Atlantic City(1)
Gorten, Manfred L., 669 Elizabeth av., Newark (7)
Gosper, Ralph W., 5719 Westf'd av.,Penns'k'nTsp.(4)
Gottlieb, Morris, 1616 Pacific av., Atlantic City (1)
Gould, John H., 92 Monte Vista av., Ridgewood (16)
Gould, Louis F., 95 Market st., Perth Amboy (12)
Gould, Werner, 219 Passaic st., Hackensack (2)
Gove, Richard R., Jr., 46th & Blvd., Brant Beach(15)
Goyne, James B., 2663 Main st., Lawrenceville (11)
Graber, Irving, 500 Tenth av., Belmar (13)
Graeter, F. Albert, 43 Barry pl., Passaic (16)
Graft, Richard S., 44 Green av., Madison (14)
Graham, Archibald F., 42 Park av., Paterson (16)
Graham, Ernest E., 66 Clark av., Somerville (11)
Graham, Richard B., 720 Boston blvd., Sea Girt (13)
Graham, Theodore K., 279 Park av., Paterson (16)
Granelli, Humbert A., 213 Garden st., Hoboken (9)
Grant, Francis, 1224 Salem av., Hillside (7)
Grant, Raymond J., 117 S. Main st., Wharton (14)
Grant, Russell B., 100 Prospect av., Hackensack (2)
Grant, William E., 1370 Morris av., Union (20)
Grant, William F., 309 Roseville av., Newark (7)
Gras, Alfred E., 140 Roseville av., Newark (7)
Grasso, Anthony P., Army (7)
Gray, Charles M., 6th & Grape sts., Vineland (6)
Gray, John W., 142 Clinton av., Newark (7)
Gray, W. Burritt, 121 Somerset st., N. Plainfield(18)
Greeley, David M., 245 Nassau st., Princeton (11)
Green, David W., 69 Market st., Salem (17)
Green, Henry, 89 Lincoln Park, Newark (7)
Green, Martin, 1922 Pacific av., Atlantic City (1)
Green, Thomas J., New Egypt (15)
Greenberg, George A., 195 W. High st., Somerv'e (18)
Greenberg, Jacob L., 189 16th av., Newark (7)
Greenberg, Max, 29 W. Henry st., Linden (20)
Greenberg, Nathan H., 29 Osborne ter., Newark (7)
Greenberg, Philip, 1919 Boulevard, Jersey City (9)
Greenberg, Samuel, 46 Johnson av., Newark (7)
Greenberg, William B., 315 60th st., W. N. Y. (9)
Greene, Albert D., 915 Palisade av., Union City (9)
Greene, Edwin C., 61 N. Pearl st., Bridgeton (6)
Greene, Harry, 90 Duncan av., Jersey City (9)
Greene, Richard W., 32 Johnson av., Newark (7)
Greene, Robert F., 1604 Central av., Union City (9)
Greenfield, Arthur W., 50 Anderson st.,Hackens'k(2)
Greenfield, Bernard H., 691 Clinton av., Newark (7)
Greenfield, Herbert, 31 Lincoln Park, Newark (7)
Greenfield, Leonard S., 691 Clinton av., Newark (7)
Greenfield, Sylvan J., 32 S. Munn av., E. Orange (7)
Greenfield, William J., 50 Anderson st.,Hackens'k(2)
Greengrass, Jacob J., 146 Broadway, Paterson (16)
Greenwald, Eugene, 100 Hollywood av., Hillside (7)
Greenwald, Theodore L., 44 Maple av., Morrist'n(7)
Greenwell, Albert W., 6 S. Brookw'd dr.,Montcl'r(16)
Greenwood, Samuel B., 190 Clinton av., Newark (7)
Greer, Melvin A., 190 Washington st., Bloomf'd (7)
Gregory, Marie F., 50 Green Village rd., Madison(14)
Gregory, Mildred G., 64 N. Ninth st., Newark (7)
Greifinger, Marcus H., 31 Lincoln Park, Newark(7)
Greifinger, William, 22 Vassar av., Newark (7)
Grenhart, George W., 714 Market st., Camden (4)
Gricco, Anthony L., 306 S. East av., Vineland (6)
Grieco, Emil H., 19 W. 22nd st., Bayonne (9)
Grier, Robt. M., 50 E. Washington av., Pleas'ty'e(1)
Griesemer, Laurence C., 515 Locust st., Roselle (20)
Griesemer, Z. Lawrence,1145 E.Jersey st.,Eliz'b'h(20)
Griffey, William C., 1049 Haddon av., Collingsw'd(4)
Griffin, Guy B., 208 S. Centre st., Orange (7)
Griffin, Joseph P., 79 Third st., Carneys Point (17)
Griffith, Roy, 909 Broad st., Newark (7)
Grimes, Robert R., 134 Bergen av., Ridgefield P. (2)
Griscom, Lee E., 604 Broadway, Camden (4)
Grlswold, Merton L., Jr., 947 Park av., Plainfield(20)
Groff, Parker A., 159 Wash'gton av., Little Ferry(2)
Gross, Irving, 16 Grove av., Verona (7)
Gross, Max, 7401 Atlantic av., Margate City (1)
Grossbard, Paul, 211 Lexington av., Passaic (16)
Grossblatt, Philip, 31 Lincoln Park, Newark (7)
Grossman, Harold W., 2553 Boulevard, Jer. City (9)
Grossman, Morris, 921 Bergen av., Jersey City (9)
Grossman, Rubin, 377 Avenue C, Bayonne (9)
Grossman, Walter, 77 Livingston av., N.Br'sw'k(12)
Gruber, William L.,8820 Mur'ta av.,VanNuys,Cal.(7)
Grubin, Charles J., 1410 Maple av., Hillside (7)
Grubin, Harold, 690 Clinton av., Newark (7)
Grubowski, Joseph N., 477 Jersey av., Jer. City (9)
Grueninger, Edward F., 411 Cedar lane, Teaneck (2)
Gruhler, Jean A., 1616 Pacific av., Atlantic City (1)
Grundfest, Jack, 659 Kearny av., Arlington (7)
Grundfest, Philip, 53 Kearny av., Kearny (7)
Grundorfer, Joseph, 201 Lyons av., Newark (7)
Grunt, Louis, 190 Clinton av., Newark (7)
Guarrala, Joseph, 106 Florence av., Hawthorne (16)
Guglielmelli, Angelo D., 449 Hamilt'n av.,Tr'nt'n(11)
Guldice, Vincent W., Harrison av., Waldwick (2)
Guion, Edward, 1219 S. Main st., Pleasantville (1)

Gulick, James B., 363 Carteret pl., Orange (7)
Gullord, Edward G., 21 Trinity pl., Montclair (7)
Gurland, Benjamin B., 146 W. 37th st., Bayonne (9)
Gurley, Katharine A., 2671 Boulevard, Jer. City (9)
Gurnee, Quinby D., 168 Diamond Br.av.,Hawth'n(16)
Gurshman, Sol., 280 Amboy av., Metuchen (12)
Gutowski, Joseph M., 433 Brace av., P. Amboy (12)
Gutowski, Walter T., 104 Grove ter., Irvington (7)

ASSOCIATE MEMBERS

Garben, Louis F., Jr., 1182 Broad st., Bloomfield (7)
Gilmour, Thomas J.,Jr., 19 Maple av.,Keansburg(13)
Glaus, Samuel D., 328 Lincoln av., Avon (13)
Goodman, Roland D., II, 265 S. Harrison st.,E.Or.(7)
Gresser, Newton H., 286 Union st., Hackensack (2)
Guttmann, John S., 89 Mahar av., Clifton (16)

H

ACTIVE MEMBERS

Hackett, Daniel C., 132 S. Euclid av., Westfield (20)
Hadley, C. Frazer, 210 W. Maple av., Merch'tv'e(4)
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont (4)
Hafetz, M. Morris, 114 Centre st., Trenton (11)
Hager, George W., Jr., 8th & Market sts., Camden (4)
Haggerty, D. Leo, 227 N. Warren st., Trenton (11)
Hagman, Frank E., Army (7)
Hagovsky, Albert J., 301 Hackensack st., Carlst't(2)
Hahn, Katherine B., 372 Thornden st., S. Orange (7)
Hahn, William H., 198 Clinton av., Newark (7)
Haines, Emerson S., 614 Winderm're av.,Asb'yP.(13)
Haines, Keith E., 300 S. Broadway, Camden (4)
Haines, Mabel C. S., 600 Wt. Horse Pk., Audubon (4)
Halbeisen, William A., 511 Cooper st., Camden (4)
Halbstein, Bernard M., 138 Bath av., L. Branch (13)
Haldeman, Robert E., 34 Garden st., Mt. Holly (3)
Haley, Paul W., 719 Sanford av., Newark (7)
Hall, Ralph A., 547 E. Broad st., Westfield (20)
Hall, Wayne W., 515 Broadway, Paterson (16)
Hall, Winthrop H., 400 Elm st., Westfield (20)
Haller, Olga, 182 Roseville av., Newark (7)
Halligan, Earl J., 254 Montgomery st., Jersey C. (9)
Hallinger, Earl S., 517 Cooper st., Camden (4)
Hallock, Wilton J., 650 Springfield av., Summit (20)
Halnan, John J., Jr., 631 Madison av., Paterson (16)
Halpern, Herman, 143 Engle st., Englewood (2)
Halpern, Samuel, 7405 Ventnor av., Margate C. (1)
Halprin, Harry, 145 Union st., Montclair (7)
Hamburg, Meyer M., 60 N. Sixth av., HighlandP.(12)
Hamburger, Werner, 1616 Pacific av., Atlantic C.(1)
Hamilton, Lloyd A., 46 York st., Lambertville (10)
Hamilton, Robert G., 100 Main st., Orange (7)
Hamley, John J., 153 Second st., Elizabeth (20)
Hammett, Lee J., 760 N. 27th st., Camden (4)
Hampton, George R., N.J.State Hosp.,Greyst'n P.(14)
Hampton, John E., 122 Belvidere av.,Wash'gton(21)
Hanan, James T., 11 The Crescent, Montclair (7)
Hancock, Michael Q.,Third av. & River rd.,Belm'r(13)
Hand, Frederick G., 119 Irvington av., S. Orange(7)
Handler, Harry, 305 York st., Jersey City (9)
Haney, John J., 850 Hamilton av., Trenton (11)
Hanfling, Seymour L., 115 S. Munn av., E. Or. (7)
Hanrahan, James, 678 N. Broad st., Elizabeth (20)
Hansen, Harold T., 153 Irvington av., S. Orange(7)
Hansen, Harry, 1006 Park av., Plainfield (20)
Hansen, Kurt M., 410 N. Third st., Millville (6)
Hanson, Alfred S., 33 Cuthbert Blvd., Westmont(4)
Hanson, Carl G., 38 Springfield av., Cranford (20)
Hantman, Harold, 196 Roseville av., Newark (7)
Harbeson, James P., III, 460 Loucraft rd.,Had'nf'd(4)
Harden, Albert S., 510 W. Market st., Newark (7)
Harden, Albert S., Jr., 551 Ridgew'd rd., Maplew'd(7)
Hardy, John W., 53 Main st., Farmingdale (13)
Harley, Halvor L., 101 S. Indiana av., Atl. City (1)
Harley, Robison D., 101 S. Indiana av., Atlantic C.(1)
Harman. J. Reginald, 824 W. State st., Trenton (11)
Harms, Charles R., 363 Park st., Montclair (7)
Harps, James A., 72 Center st., Clinton (10)
Harrington, J. Henry, 40 E. Main st.,Rockaway(14)
Harris, Jonathan L., 1060 Broad st., Newark (7)
Harris, Leonard, 299 Clinton av., Newark (7)
Harris, Maurice N., 205 Irving av., Bridgeton (6)
Harris, Morris, 102 Broad st., Bloomfield (7)
Harris, Sidney, 301 W. Fifth av., Roselle (20)
Harris, William O., 32 N. New Jer. av., Atl. City (1)
Harryman, William K., 271 Union st., Hackens'k(2)
Harter, Louis F., 174 Bowers st., Jersey City (9)
Hartman, Luther M., 111 E. Main st.,Maple Shade(3)
Hartman, Winfield L., Jr., 7 Fielding ct., S. Or.(7)
Hartmann, Edmund M., 1414 Chetw'd av.,Plainf'd(18)
Hartwell, H. Ameroy, 777 Boulevard,E.,Weeh'ken(9)
Harvey, Robert K., 711 Kearny av., Arlington (7)
Harvey, Thomas W., 59 Main st., Orange (7)
Harwood, Harry L.,64 W.CentralBlvd.,PalisadesP.(2)
Harz, William V., 880 Avenue C, Bayonne (9)
Haschec, Walter, 690 S. 19th st., Newark (7)
Hasking, Arthur P., 318 Montgomery st., Jer.City(9)
Hasney, Frederick A., 118 Main st., West Orange(7)
Hatch, Harold S., Shonghum Mt. Sana.,Morrist'n(14)
Hatem, Elias J., 1046 Main st., Paterson (16)
Hathaway, George, Jr., 149 Prospect st., Passaic(16)
Hauber, Eugene A., 198 Wash'gton rd., Sayrev'e(12)
Hauck, Francis A., 4614 Landis av., Sea Isle City(5)
Hauck, Lydia R. B., 644 Stuyvesant av., Irv'gton(7)
Hauck, William H., 644 Stuyvesant av., Irv'gton(7)
Hauptman, Harry, 88 Sherman pl., Jersey City (9)
Hausman, Samuel W., 50 W. Front st., Red Bank(13)
Haut, Edward M., 21 Main st., Farmingdale (13)
Haut, Gail W., 32 General Wayne Vil., Madison (14)
Hawes, Vernon L., 63 Church st., Ramsey (2)
Hawkes, E. Zeh, 161 Roseville av., Newark (7)
Hawkes, Stuart Z., 161 Roseville av., Newark (7)
Hayes, Gerald W., 86 Hawthorne av., E. Orange(7)
Hayman, Irving R., 681 Broadway, Paterson (16)
Hays, Roy G., 527 Haddon av., Collingswood (4)
Haywood, Henry, 49 Paterson st., N. Brunsw'k(12)
Heatley, William, 29 Drummond pl., Red Bank(13)
Hebble, Howard M., 320 Chester av., Moorestown(3)
Hegeman, Runkle F., 161 W. High st., Somerv'e(18)
Heilbrunn, Julius, 2540 Boulevard, Jersey City (9)
Heineken, Theodore S., 17 Park pl., Bloomfield (7)
Helsen, Aaron J., Imlaystown (13)
Hekimian, Jacob H., 2314 Palisade av.,Weeh'wk'n(9)
Helff, Joseph R., 1367 Teaneck rd., W. Englewood(2)
Heller, Abraham R., 494 Belgrove dr., Arlington (7)
Heller, George, 460 Engle st., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)

Hely, Charles J., Jr., 564 Summit av., Westfield (20)
Heminway, Norman L.,106 Short Hills av.,Sh't H.(20)
Hemphill, Everett H., 274 Kings Hwy.,E.,Had'nf'd(4)
Henderson, Worth W., 469 W. Front st., Plainf'd(20)
Hendrickson, Harold W., Edgewood av.,Cedarville(6)
Henle, Carye-Belle, 202 Clinton av., Newark (7)
Hennig, Paul F., 688 Stuyvesant av., Irvington (7)
Henriksen, J. Bruce, 422 River av., P. Pleasant(15)
Henry, Frank C., Jr., 214 Smith st.,Perth Amboy(12)
Henry, George, 33 Mine st., Flemington (10)
Henry, Norman, 643 Wood st., Vineland (6)
Henshaw, George R., 228 Midland av., Montclair(7)
Hensle, Otto S., 210 Main st., Hackensack (2)
Herbener, Eugene G., 423 Third st., Lakewood (15)
Herman, Isadore, 119 Quincy st., Passaic (16)
Hermann, John H., 197 S. Centre st., Orange (7)
Hermann, John H., Jr., 197 S. Centre st., Orange (7)
Herndon, Lewis S., 144 Harrison st., East Orange(7)
Herrington, Lee R., 643 E. Broad st., Westfield(20)
Herrman, William G., 501 Grand av.,AsburyPark(13)
Hershey, Harry H., 921 Bergen av., Jersey City (9)
Hersohn, William W., 14 N.Rumson av.,Marg'e C.(1)
Hertzberg, Irving, 586 Kearny av., Kearny (7)
Hess, L. Elmore, 19 E. Bolton av., Absecon (1)
Hesseltine, Clair E., 305 Main st., South Amboy(12)
Hessert, Edmund C., 417 Cooper st., Camden (4)
Hewson, George F., 21 Roseville av., Newark (7)
Heyman, Arthur, 89 Lincoln Park, Newark (7)
Heyman, Jacob, 846 S. 12th st., Newark (7)
Heymann, Ernest F., 345 Broad st., Red Bank (13)
Hicks, Alfred M., 149 Park st., Montclair (7)
Hiden, Joseph C., 199 Nassau st., Princeton (11)
Higgins, Eugene V., 1180 Raymond blvd.,Newark(7)
Higgins, John T., 145 Highland av., Jersey City (9)
Higgins, Thomas A., 2616 Boulevard, Jersey City (9)
Hiler, Stuart A., 62 Rockaway av., Rockaway (14)
Hilker, George F., 258 Maple st., Perth Amboy (12)
Hill, Arthur G., 324 Grove st., Montclair (7)
Hill, Clarence T., 116 E. Hazelwood av., Rahway(20)
Hill, Dean F., Sussex (19)
Hill, James O., 84 Barclay st., Newark (7)
Hill, Robert H., 227 Roseville av., Newark (7)
Hillel, Joseph, 425 77th st., North Bergen (9)
Hilliard, William T., 105 Market st., Salem (17)
Hillman, Ernest C., Jr., 300 Broadway, Newark (7)
Hillmann, Frederick C., 64 Hamilton st.,Paterson(16)
Hillsman, R. Bryan, 681 Queen Anne rd., Teaneck(2)
Hilton, Clarence O., 556 N. Seventh st., Newark (7)
Hinckley, Livingston S., 182 Clinton av., Newark(7)
Hindle, F. Lawton, 145 Maple av., Red Bank (13)
Hingston, William L., 110 Main st.,Williamstown(8)
Hipple, Percy L., 118 E. Fifth av., Roselle (20)
Hird, Emerson F., 118 E. Maple av., Bd. Brook (18)
Hirsch, Albert, 1554 Irving st., Rahway (20)
Hirsch, Arthur, 811 DeHirsch av., Woodbine (5)
Hirsch, John J., 191 Wallington av., Wallington (2)
Hirsch, Lucien, 160 E. Seventh st., Plainfield (20)
Hirsch, Solomon, 2553 Boulevard, Jersey City (9)
Hirsch, Theodore, 842 S. 13th st., Newark (7)
Hirschfield, Bernard A., 375 W. State st.,Trenton(11)
Hirshorn, Arthur, 539 Monmouth st., Gloucester (4)
Hitschmann, Otto B., 97 Lincoln Park, Newark (7)
Hitzemann, Louis A., 35 Pangborn pl., Hackensack(2)
Hnat, Frederick, 565 Newark av., Elizabeth (20)
Hobart, Richard T., 454 Park st., Up. Montclair (7)
Hoch, Samuel M., 240 Hillside rd., Elizabeth (20)
Hochheimer, Arthur, 417 Somerset st., Bd.Brook(18)
Hochman, Alex, 260 Hamilton av., Paterson (16)
Hodas, Sidney M., 268 Broad st., Red Bank (13)
Hofbauer, Ernest, 608 Parkway av., Trenton (11)
Hofer, Clarence J. M., 463 Main st., Metuchen (12)
Hofer, William R., 125 Main st., Williamstown (4)
Hoffman, Charles A., 302 E. Seventh st., Plainf'd(20)
Hoffman, Charles W.,216 Bordent'n av.,S.Amboy(12)
Hoffman, Florentine M., 91 Bayard st.,N.Br'sw'k(12)
Hoffman, George A., 234 Fort Lee rd., Leonia (2)
Hoffman, Harry, 805 Park av., Plainfield (20)
Hoffman, Harry S., 3302 Pacific av., Atlantic City(1)
Hogan, Marshall D., 311 W. Main st., Boonton (14)
Holder, Lester, 1750 Walker av., Union (7)
Holderith, Albert E., 15 Virginia av., Livingston (7)
Holland, Reuben J., 1026 Chandler av., Linden (20)
Hollingsworth, H. Hale, 86 First st., Clifton (16)
Hollinshed, Beulah S., 600 Benson st., Camden (4)
Hollinshed, Ralph K., 351 Broadway, Westville (8)
Hollywood, James L., 219 Danforth av., Jer. City(9)
Holman, Francis W., 123 Broad st., Keyport (13)
Holmes, George J., 17 Elizabeth av., Newark (7)
Holmes, Grace A., 1077 E. Jersey st., Elizabeth (20)
Holmes, H. David, 15 N. Indiana av.,Atlantic City(1)
Holmes, Thomas J. E., 151 Fair st., Paterson (16)
Holoman, M. Browne, 1 N. Haverford av.,Marg'e(1)
Holster, Stephen G., 951 Madison av., Paterson (16)
Holt, Evelyn, 261 Springfield av., Summit (20)
Holt, Herman H., 576 Broadway, Paterson (16)
Holters, Otto R., 1002 Emory st., Asbury Park (13)
Holtz, Harry M., 299 Clinton av., Newark (7)
Holtzman, Michael, 734 N. Broad st., Elizabeth(20)
Hoops, Harold J., 25 Woodland Pk. dr., Tenafly (2)
Hooton, Thomas C., 31 Trinity pl., Montclair (7)
Hopper, Guy R., 147 Elmer st., Westfield (20)
Hopper, John B., E. Main st., Mendham (14)
Hopping, John S., River rd., Hanover (14)
Hopping, Richard A., 15 Washington st., Newark(7)
Horhovitz, George I., 324 S. Broad st., Trenton (11)
Horland, Aaron H., 37 Chancellor av., Newark (7)
Horn, Harry, 622 Stuyvesant av., Irvington (7)
Horn, Helen A., Mountainside Hosp., Montclair (7)
Horn, Max, 850 S. 11th st., Newark (7)
Hornberger, J. Howard, 4th & Main sts.,Roebling(3)
Horner, John I., 137 W. King's Highway,Audubon(4)
Hornick, Emil E., 6 Altamont ct., Morristown (14)
Hornstine, Harry H., 4004 Pacific av., Wildwood (5)
Horoschak, Anne, 974 Park av., Plainfield (20)
Horowitz, Alexander S., 4614 Boulevard, Union C.(9)
Horowitz, Herman J., 872 Broad av., Ridgefield (2)
Horowitz, Leo, 3644 Boulevard, Jersey City (9)
Horre, George W. H., 203 W. Jersey st.,Elizabeth(20)
Hosay, John, 243A Second st., Jersey City (9)
Hosp, Paul H., 842 S. 12th st., Newark (7)
Howard, J. Edgar, 67 Kings Hwy.,W.,Had'nf'd (4)
Howell, E. Gaylord, 120 New st., N. Brunswick (12)
Howell, Thomas W., Army (7)
Howeth, John L., 14 Duncan av., Jersey City (9)
Howley, Barth, Jr., 116 Livingston av.,N.Br'sw'k(12)
Hubach, Maximilian F.,Jr.,307M'tgom'y st.,Bl'mf'd(7)
Hubbard, Robert Y., Fernwood Lodge, Hewitt (7)
Huber, William H., 587 Prospect st., Maplewood (7)
Huberman, John, 853 S. 12th st., Newark (7)
Huberman, Victor, 853 S. 12th st., Newark (7)
Hubert, Antonio O., 131 E. Main st., Rockaway (14)
Hughes, A. Joseph, 3rd & Cooper sts., Camden (4)
Hughes, Frank J., 429 Cooper st., Camden (4)
Hughes, Harold F., Ocean st.& Col'bia av.,Cape M.(5)
Hughes, J. Vernon, P. O. Box 454, Passaic (16)
Hughes, Joseph F., 16 N. Broad st., Woodbury (8)
Hughes, Lee W., 965 Broad st., Newark (7)
Hughes, Samuel B., 246 E. Pine av., Wildwood (5)
Hughes, Thomas E., 223 Cooper st., Camden (4)
Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
Hull, Donald B., 88 W. Ridgewood av., Ridgewood(2)
Humbert, Joseph C., Jr., Stewartsville (21)
Hummel, Ernest G., 414 Cooper st., Camden (4)
Hummel, Frederick W., 606 F st., Belmar (13)
Hummel, Lee C., 109 W. Broadway, Salem (17)
Humphrey, Hubert G., 430 Downer st., Westf'd(20)
Humphries, Robert E., 637 Central av., E. Orange(7)
Hunt, John A., Chambers W. Hosp., Penns Gr. (17)
Hunt, Melvin M., 140 Jackson st., South River (12)
Hunt, Thomas F., 528 Monroe av., Elizabeth (20)

Hunter, Floyd D., 3620 Nott'gh'm way,Ham't'n S.(11)
Hunziker, George P., 435 Warw'k av.,W.Englew'd(2)
Hurff, J. Wallace, 671 Broad st., Newark (7)
Hurtado, Edward, Redfield Village, Metuchen (12)
Huss, Louis, 1722 Boulevard, Union City (9)
Hussong, Wallace B., 225 N. Seventh st., Camden(4)
Husted, Gerald W., 306 Eighth av., Haddon Hts.(4)
Husted, Samuel H., Main rd., Neshanic (18)
Hutcheson, Robert B., 215 Delaware st.,Woodb'ry(8)
Hutchinson, A. Dunbar, 913 W. State st.,Trenton(11)
Hutchinson, George F.,Yardville av.,Hamilton S.(11)
Hutner, Cyril I., 134 Grove av., Woodbridge (12)
Hutton, Frederick T., 717 Watchung av.,Plainf'd(20)
Hyde, Robert T., Navy (7)
Hyer, Godfrey S., 199 W. High st., Somerville (18)
Hyland, Michael, 197 Kearny av., Kearny (7)
Hyman, Charles, 2807 Pacific av., Atlantic City (1)
Hymes, Ben, 66 Baldwin av., Newark (7)

ASSOCIATE MEMBERS

Halsted, Harry C., 77 Hawthorne av., Nutley (7)
Helden, Gerard O., 15 Anderson st., Hackensack (2)
Hennessy, John, Paterson Gen. Hosp., Paterson(16)
Herbert, William A., 501 Washington av., Avon (13)
Higdon, Albert L., 411 Cedar lane, Teaneck (2)
Hines, Harrison R., 710 Grand av., Asbury Pk. (13)
Holland, John W., 4 S. Haverford av., Margate C.(1)
Honig, Charles, 24 High st., Butler (16)
Howe, Edward G., 763 Broad st., Newark (7)
Howland, Jonathan, 62 Stanw'th lane, Princet'n(11)
Hurewitz, Benjamin, 0-95 Midland av.,Fair L'wn(16)
Hutchinson, Wm. M.,1457 Nott'gh'm W.,Trent'n(11)

I

ACTIVE MEMBERS

Ianacone, John A., 310 Fifth av., Paterson (16)
Iatesta, Matthew, 60 Northfield av., W. Orange (7)
Ill, Edmund W., 477 Mt. Prospect av., Newark (7)
Ill, Herbert M., 42 Woodland av., Glen Ridge (7)
Imbleau, Joseph E. L., 2106 Morris av.,Unionv'le(20)
Imhoff, John G., 913 Summit av., Jersey City (9)
Imhoff, Robert E., 527 Penn st., Camden (4)
Infield, Gerald L., 707 Shore rd., Northfield (1)
Inge, Hutchins F., 205 S. Orange av., Newark (7)
Insabella, John, 317 S. Orange av., Newark (7)
Insolera, John A., 388 Park av., Paterson (16)
Introcaso, Dominick A., 45 Crescent av., Jer. City(9)
Iraggi, James V., 53 Passaic av., Passaic (16)
Irmisch, George W., 375 W. State st., Trenton (11)
Ironside, Paul A., 144 North dr., Haddonfield (4)
Irving, Henry C., 27 Warner av., Jersey City (9)
Irwin, Francis T., 51 Forest av., Caldwell (7)
Irwin, James R., 1402 Muirlands dr.,LaJolla, Calif.(7)
Irwin, John H., 242 Engle st., Englewood (2)
Irwin, Robert C., 541 Page av., Lyndhurst (2)
Isaac, Benoit C., 83 Central av., Orange (7)
Isen, Paul J., 600 Third av., Bradley Beach (13)
Israel, Joseph, 252 Washington av., Belleville (7)
Israeloff, Howard H., 1038 Clinton av., Irvington (7)
Ittleman, William S.,307 N.Wash'gt'n av.,D'nel'n(12)
Ivey, Evelyn P., 3 Community pl., Morristown (14)
Izenberg, David, 555 E. 29th st., Paterson (16)

ASSOCIATE MEMBERS

Iandoli, John, 227 Washington av., Westwood (2)
Ibranyi, Gustav L., 413 Roseville av., Newark (7)

J

ACTIVE MEMBERS

Jack, H. Wesley, 538 Cooper st., Camden (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Charles H., 1250 Park blvd., Camden (4)
Jackson, George H., 100 Elmwood av., Union (7)
Jacobitti, Edmund E., 491 Maywood av., Mayw'd (2)
Jacobs, Alan L., 1243 Stuyvesant av., Union (20)
Jacobs, Benjamin, 1612 Clinton pl., Hillside (7)
Jacobs, William, 1030 Stuyvesant av., Irvington (7)
Jacobson, Benjamin D.,187Liv'gst'n av.,N.Br'sw'k(12)
Jacobson, J. Joseph, 1616 Pacific av., Atl. City (1)
Jacobson, Murray B., 137 Market st., P. Amboy (12)
Jaeckle, Charles E., 136 Evergreen pl., E. Orange(7)
Jaffe, Benjamin, 566 Bergen av., Jersey City (9)
Jaffe, Hyman, 149 Broadway, Passaic (16)
Jaffin, Abraham E., 41 Emory st., Jersey City (9)
Jahn, Albert G., 657 Main av., Passaic (16)
James, Bart M., 15 Washington st., Newark (7)
Jamison, William F., 501 Grand av., Asbury Pk.(13)
Jani, Frank F., 297 Lexington av., Passaic (16)
Jaques, J. Eugenia, 74 Waverly st., Jersey City (9)
Jarecki, Max M., 905 Bergh st., Asbury Park (13)
Jarvis, Daniel G., 31 Lincoln Park, Newark (7)
Jasionowski, Edward, 121 Main st., Sayreville (12)
Jaslow, Seymour P., Godwin av., Wyckoff (2)
Jaso, James V., 710 Varsity rd., South Orange (7)
Jaspan, Samuel C., 820 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jehl, Joseph R., 59 Harding av., Clifton (16)
Jenkins, Alvah R., 40 Armory st., Englewood (2)
Jenkins, Arthur M., 701 Harrison st., Frencht'n(10)
Jenkins, R. Jewett, 683 High st., Newark (7)
Jennings, Robert E., 117 Wash'gton st.,E. Orange(7)
Jentz, John H., 67 Sherman pl., Jersey City (9)
Joelson, Dora, 485 Park av., Paterson (16)
Joelson, Morris S., 577 Broadway, Paterson (16)
Joffe, Philip M., 556 E. 28th st., Paterson (16)
Joffe, Sidney H., 556 E. 28th st., Paterson (16)
Johnsen, Sigurd W., 149 Prospect st., Passaic (16)
Johnson, Archie W., 169 Claremont av., Jersey C.(9)
Johnson, G. Leonard, 390 Booth av., Englewood (2)
Johnson, George F., Branchville (19)
Johnson, Harold F., 734 Park av., Plainfield (20)
Johnson, Herbert F., 429 Cooper st., Camden (4)
Johnson, John F., 926 W. State st., Trenton (11)

Johnson, Robert A., 68 Roseville av., Newark (7)
Johnson, V. Earl, 101 S. Indiana av., Atlantic City(1)
Jonas, August, 328 E. Broadway, Salem (17)
Jones, Helen E., 601 Grand av., Asbury Park (13)
Jones, Herbert E., 6 Hillside rd., Elizabeth (20)
Jones, John C., 805 Princeton av., Camden (4)
Jones, Lewis H., 139 E. Grant av., Roselle Park (20)
Jones, William F., 21 East High st., Somerville (18)
Jonitz, Robert, 153 S. Grove st., East Orange (7)
Jordan, Joseph C., 238 E. Main st., Manasquan (13)
Jordan, Walter L., 145 Engle st., Englewood (2)
Joseph, Benjamin M., 2771 Boulevard, Jersey City(9)
Joseph, Morris, 271 Lexington av., Passaic (16)
Joseph, Solomon, 877 Queen Anne rd., Teaneck (2)
Judd, Joseph, Jr., 300 Westfield av., Elizabeth (20)
Judge, John F., 577 S. Orange av., S. Orange (7)
Judge, Thomas V., Jr., Mem. Hosp., Syracuse,N.Y.(7)
Judson, G. Vernon, Jr., 722 Redman av., Had'nf'd(4)
Judy, Kenneth H., 2741 Boulevard, Jersey City (9)
Jukofsky, Isidore D., 335 Main st., Ridgef'd Pk. (2)
Jurewicz, Stanley T., 290 17th av., Paterson (16)
Just, Francis, 564 High st., Newark (7)
Justin, Arthur W., 41 Fulton st., Weehawken (9)

ASSOCIATE MEMBERS

Jenkins, John R., Jr., 15 Pleasant ct., Maywood (2)
Johnson, Ernest E., 214 Lexington av., Passaic (16)

K

ACTIVE MEMBERS

Kaderabek, Erwin J., 144 Harrison st., E. Orange(7)
Kadisch, Ernst L., 120 Second av., Westwood (2)
Kahn, Leo, 32 States av., Atlantic City (1)
Kahrs, Grace M., 311 Mt. Prospect av., Newark (7)
Kahrs-Dreyfors, Madeline, N.J.State H.,Marlb'ro(13)
Kain, Thomas M., 403 Cooper st., Camden (4)
Kain, Thomas M., Jr., 403 Cooper st., Camden (4)
Kainer, Herbert, 4411 Boulevard, North Bergen (9)
Kakascik, Emil J., 206 Palisade av., Garfield (2)
Kalb, S. William, 416 Clinton pl., Newark (7)
Kaletkowski, Marion F., 4 Englewood rd.,Clifton(16)
Kalter, George E., 640 Prospect st., Maplewood (7)
Kaman, Samuel L., 1616 Pacific av., Atl. City (1)
Kandra, Paul H., 153 Mountain av., Westfield (20)
Kanengiser, Clifford H., 26 Gifford av., Jer. City (9)
Kaney, Emil M., 74 Clinton av., Newark (7)
Kant, Emanuel R., 240 High st., Perth Amboy (12)
Kaplan, Elliot L., 251 Meeker av., Newark (7)
Kaplan, Harry, 186 W. State st., Trenton (11)
Kaplan, Herman B., 324 44th st., Union City (9)
Kaplan, Samuel D., 615 N. Broad st., Elizabeth (20)
Kaplan, Sidney, 285 Lexington av., Passaic (16)
Kapp, Carl G., 440 Westminster av., Elizabeth(20)
Karel, Jack R., 407 Jersey av., Elizabeth (20)
Karnay, Francis, 416 Center st., Garwood (20)
Karshmer, Ernest E., 420 Wood av., N., Linden (20)
Karshmer, Nathan, 92 Carroll pl., N.Br'nsw'k (12)
Kassel, Mortimer H., 34 Elmwood ct., E.Pat'rs'n(16)
Kassow, Philip B., North Boulevard, Alpha (21)
Kastler, Franz, 54 Ames av., Rutherford (2)
Katz, Harry, 494 Park av., Paterson (16)
Katz, Herbert I., 44A Boulevard, E. Paterson (16)
Katz, Sidney, 8116 Boulevard, North Bergen (9)
Katz, Theodore, 540 S. Wood av., Linden (20)
Katzin, Eugene M., 50 Baldwin av., Newark (7)
Kauder, Warren G., 201 Lyons av., Newark (7)
Kauffmann, Louis J., 228 N. Second st., Millv'e (6)
Kaufman, Jerome G., 299 Clinton av., Newark (7)
Kavanaugh, Daniel E., 566 Mt. Prosp't av.,New'k(7)
Kawalek, Roman, 592 Park av., East Orange (7)
Kay, Albert E., 5 W. Chestnut av., Merchantv'e (4)
Kaycoff, Aaron J., 628 Wood av., N. Linden (20)
Kaye, Bernard, 245 Bath av., Long Branch (13)
Kazmann, Harold A., 601 Grand av., Asbury Pk.(13)
Kearney, Edward P. J.,83 S.Fullert'n av.,Montcl'r(7)
Kearney, Hugh, 323 N. Main st., Pleasantville (1)
Kearney, John F., 238 Hilton av., Maplewood (7)
Kearney, Paul A., 12 Woodcraft pl., Short Hills (7)
Keating, Charles A., 177 Ellison st., Paterson (16)
Keating, Joseph M., 657 Main av., Passaic (16)
Keats, Sidney, 31 Lincoln Park, Newark (7)
Keeney, Cadwell B., 137 Summit av., Summit (20)
Kehler, James G., Jr., Underwood Hosp.,Woodb'y(8)
Keil, Sigmund S., 1118 St. George av.,E., Linden(20)
Keim, William F., Jr., 15 Washington st., New'k(7)
Keir, Floyd E., 308 Engle st., Englewood (2)
Keith, Theodore R., 159 Passaic av., Passaic (16)
Kelemen, Edward, 875 Broadway, Long Branch (13)
Kelemen, Nicholas M., 315 Central av., E. New'k(7)
Keller, Earl B., Jr., 604 Wt. Horse Pk., Oaklyn (4)
Keller, Michael L., 673 E. 27th st., Paterson (16)
Kelley, Charles B. P., 336 Engle st., Tenafly (2)
Kelley, Ray H., 72 Wyckoff av., Midland Park (16)
Kelly, Bernard S., 1954 Boulevard, Jersey City (9)
Kelly, Frank, 11 N. Johnson Blvd., Gloucester (4)
Kelly, J. Paul, 30 Ridgedale av., Morristown (14)
Kemeny, George, 39 Third st., Elizabeth (20)
Kemeny, Imre, 48 Pulaski av., Carteret (12)
Kemezis, Vitas, Closter Dock rd., Closter (2)
Kemp, Norval F., 87 Sherman pl., Jersey City (9)
Kempe, George, 963 Caldwell av., Union (7)
Kennedy, A. Andrew, 121 Hadley av., Clifton (16)
Kennedy, Eugene T., 413Wanaque av.,Pompt'nL.(16)
Kennedy, George R., 517 Cooper st., Camden (4)
Kennedy, John N., 831 Madison av., Plainfield (20)
Kennedy, Paul A., 147 Tenafly rd., Englewood (2)
Kennedy, Wm. M.,413 N.Main st.,Morresv'le,N.C.(7)
Kenny, James, 18 Fairway dr., West Orange (7)
Kent, Donald F., 396 Main st., Chatham (14)
Kent, Louis R., 1974 St. Georges av., Rahway (20)
Kerdasha, Richard F., 937 Monmouth st.,Glouc't'r(4)
Kern, E. Clarence, 45 Park st., Montclair (7)
Kern, Meyer J., 144 Clinton av., Newark (7)
Kerr, Andrew D., Jr., 19 Lincoln av., Clifton (16)
Kertis, Eugene R., 272 E. Second av., Roselle (20)
Kesselman, Samuel R., 29 Stratford pl., Newark (7)
Kessler, Henry B., 40 Clinton pl., Newark (7)
Kessler, Henry H., 53 Lincoln Park, Newark (7)
Keyser, David, 1518 Baird av., Camden (4)
Keyssar, Alexander, 18 Isabella av., Newark (7)
Kidd, Ruth W., 1199 Morris av., Union (20)
Kiely, Eugene M., 800 Hudson st., Hoboken (9)
Kiessling, Charles E., 763 Broad st., Newark (7)
Kieswetter, Dayton T., 75 Prospect st., E. Orange(7)
Kiley, John E., 94 Park st., Montclair (7)
Kilts, Winfield S., 966 Garrison av., Teaneck (2)
Kim, Gay B., 703 Main st., Paterson (16)
Kimche, Irwin, 37 Rawley pl., Millburn (7)
Kimler, William D., 400 Collings av., Collingsw'd (4)
Kimmel, Charles, 488 Broad st., Bloomfield (7)

Kimmel, M. Leonard, 3342 Boulevard, Jer. City (9)
Kimmel, Seymour S., Oxford (21)
Kinczel, John A., 971 S. Broad st., Trenton (11)
King, Alden P., 400 W. Blackwell st., Dover (14)
Kingslow, George L., 346 First st., Hackensack (2)
Kinley, John W., 111 Clinton av., Newark (7)
Kinney, Albert G., 609 Clinton av., Haddonf'd (4)
Kirkman, Leroy G., 176 Roseville av., Newark (7)
Kirschner, Martin I., Vernon (19)
Kissinger, Donald J., 315 Engle st., Tenafly (2)
Klapper, Lester L., 967 Park av., Plainfield (20)
Klarich, Philip, 512 Broadway, Camden (4)
Kleiber, Estelle E., 131 Liv'gston av., N. Br'sw'k(12)
Klein, Alfred, 6-25 Plaza rd., Fair Lawn (16)
Klein, Andrew J. V., 94 Hawthorne av., E. Orange(7)
Klein, Edward C., Jr., 73 Lincoln Park, Newark (7)
Klein, Edward F., 136 Market st., Perth Amboy (12)
Klein, Julius, 2105 Palisade av., Union City (9)
Klein, Michael, 1540 Spr.Valley dr.,Hunt'gt'n,W.V.(7)
Klein, Solomon, 11 High st., Morristown (14)
Klein, William, 85 Bayard st., New Brunswick (12)
Kleiner, Charlotte A., 330 Crescent av., Leonia (9)
Kleiner, Samuel, 162 Hamilton av., Paterson (16)
Kleinman, Maurice, 101 Clinton av., Newark (7)
Kleinmann, Eberhart H., 560 Broadway,Paterson(16)
Klempner, Paul, 637 Greenwood av., Trenton (11)
Klenk, Joseph P., 328 Belleville av., Bloomfield (7)
Kler, Joseph H., 151 Liv'gston av., N. Br'nsw'k (12)
Kline, George L., 519 Mt. Prospect av., Newark (7)
Kline, Herman, 2643 Pacific av., Atlantic City (1)
Kline, Joseph J., 733 Hamilton av., Trenton (11)
Kline, Nathan S., 41 Beechwood rd., Summit (20)
Kline, Oram R., 514 Cooper st., Camden (4)
Klinger, John S., 1452 Mt. Ephraim av.,Camden(4)
Kloby, John J., 562 Bayway, Elizabeth (20)
Klompus, Irving, 301 E. High st., Bound Brook (18)
Klosk, Emanuel, 324 Radel ter., South Orange (7)
Klosterman, Julius A., 335 River rd., Bogota (2)
Klostermyer, Louis L., Mount'ns'e Hosp.,M'ntcl'r(7)
Kluft, Jack M., 280 Hobart st., Perth Amboy (12)
Klughaupt, Dorothy K., 257 Boulevard, Passaic (16)
Knapp, Richard E., 25 Hudson st., Hackensack (2)
Knauer, Charles H., Jr., 214 W. State st.,Trenton(11)
Knauer, George, 930 Elizabeth av., Elizabeth (20)
Knight, William T., 210 Main st., Hackensack (2)
Knowles, George M., 403 Prospect av., Hackens'k(2)
Knowles, James S., 318 N. Second st., Millville (6)
Knox, Charles A., 138 Bergen av., Ridgef'd Pk.(2)
Knox, Harriet L., 390 Union st., Hackensack (2)
Kobes, John J., 138 Kearny av., Kearny (7)
Koch, James, 776 S. 19th st., Newark (7)
Koch, William, 601 Grand av., Asbury Park (13)
Koeck, George P., 305 Roseville av., Newark (7)
Koelsch, Fred k J. E., 14 Kirkp'tr'k st., N.Br'sw'k(12)
Koenig, Bertram, 282 Broadway, Paterson (16)
Koerber, George, 136 Prospect st., Passaic (16)
Kohn, Joseph J., 143 E. State st., Trenton (11)
Kohn, Leo, 86 Park pl., South Orange (7)
Kohut, George J., 436 Amboy av., Perth Amboy (12)
Kolb, John M., 1611 Boulevard, North Bergen (9)
Kollmar, Robert, 617 W. 168th st., N. Y. C. (7)
Kolodin, Abraham, 185 Broad st., Bloomfield (7)
Kondor, Joseph S., 1414 S. Broad st., Trenton (11)
Konzelman, Henry J., 65 King st., Hillside (20)
Konzelmann, Frank W., 304 S. Shore rd., Absecon(1)
Kook, Sol, 54 Grand pl., Arlington (9)
Kooperstein, Samuel I., 191 Palisade av., Jer.City(9)
Koplin, Nathaniel H., 142 W. State st., Trenton (11)
Koralek, Adolph H., 31 Lincoln Park, Newark (7)
Korman, Arnold, 24 Dey st., Clifton (16)
Kornfeld, Werner, 645 Central av., East Orange (7)
Kornfield, Norman B., 52 Livingston av.,Arlingt'n(9)
Kosterlitz, Henry H., 640 Stuyvesant av., Irv'gton(7)
Kovaleski, Walter A., 77 Market st., Passaic (16)
Kovin, Abraham, 123 Lexington av., Passaic (16)
Kraemer, Louis B., 74 Baldwin av., Newark (7)
Kraemer, Samuel H., 309 Baldwin av., Jersey City(9)
Krafchik, Louis L., 158 Livingston av.,N.Br'sw'k(12)
Kraissl, Cornel's J., 230 Kind'km'k rd., N. H'k'ns'k(2)
Kraker, David A., 31 Lincoln Park, Newark (7)
Krakower, Alvin H., 528 E. 29th st., Paterson (16)
Kramer, Bernard M., 254 State st., Perth Amboy(12)
Kramer, Douglas W., 1019 Park av., Plainfield (20)
Kramer, Samuel E., 254 State st., Perth Amboy (12)
Kratka, William H., 188 N. Pearl st., Bridgeton (6)
Krauss, Fletcher I., 407 Main st., Chatham (14)
Krausz, Emery, 577 S. Main st., Phillipsburg (21)
Kraut, Arthur M., 681 Bergen av., Jersey City (9)
Krechmer, Abraham, 400 Pacific av.,AtlanticCity(1)
Kreutz, Paul J., 363 Union av., Elizabeth (20)
Krichbaum, Carroll E., Army (7)
Kristal, John, 292 Main st., Hackensack (2)
Krone, William F., 31 Lincoln Park, Newark (7)
Krudener, Robert D., 230 Fulton ter., Cliffside P.(2)
Krug, Alfred J., 1460 Clinton av., Irvington (7)
Kruger, William, 31 Lincoln Park, Newark (7)
Krugman, Benjamin M., 438 Park av., Paterson(16)
Kuchlewski, Edward J., 224 E. Jersey st.,Eliz'b'h(20)
Kuder, Joseph M., 104 Garden st., Mt. Holly (3)
Kuhlmann, Alvin E., 527 37th st., Union City (9)
Kuite, George B., 435 Speedwell av., Morris Pls.(14)
Kulick, Morton, 731 14th av., Paterson (16)
Kummel, Max, 31 Lincoln Park, Newark (7)
Kump, Albert B., 39 Lake st., Bridgeton (6)
Kun, Bertram, 135 Belmont av., Jersey City (9)
Kunderman, Philip J., 215 Harper st., Highl'd P.(12)
Kunz, Harold G., 64 Hawthorne pl., Montclair (7)
Kuperman, Henry L., 79 Baldwin av., Newark (7)
Kurtz, Gerald I., 306 Broadway, Paterson (16)
Kurtz, Geza R., 116 Fairview av., Jersey City (9)
Kushner, Alexander, 208 W. Milton av., Rahway(20)
Kustrup, John F., 1418 S. Broad st., Trenton (11)
Kutner, Charles, 211 N. Fifth st., Camden (4)
Kyhos, Emma D., 314 Hillside av., Nutley (7)
Kyle, Ernest I., 205 W. Ninth st., Plainfield (20)

ASSOCIATE MEMBERS

Katz, Emanuel, 9 Kirkpatrick st., N. Brunsw'k(12)
Katz, Michael M., 197 S.Washington av.,Berg'nf'd(2)
Kennedy, Joseph F., 347 Valley rd., Clifton (16)
Kenney, Howard W., 653 High st., Newark (7)
Kessler, Morris, 626 Schuyler av., Arlington (7)
Kley, Edward, 199 Dorchester rd., River Edge (2)
Kloth, Edward W., 254 Christie Hts. st., Leonia (2)
Kolisch, Paul deR., 39 Waldron av., Glen Rock (16)
Krull, Bernard, 811 Queen Anne rd., Teaneck (2)
Kuhn, William, Mass.Gen.Hosp.,Boston 18,Mass.(12)

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ACTIVE MEMBERS

Laauwe, Harold W., 500 Market st., Paterson (16)
LaBarba, Peter J., 163 Washington pl.,Hasbr'kH.(2)
Labow, Joseph J., 757 N. Broad st., Elizabeth (20)
Lafferty, Elton B., 69 Orange av., Irvington (7)
Lakiszak, Roman T., 162 Harrison av., Jer. City (9)
Lamberto, Vito A., 422 Stuyvesant av.,Lyndhurst(2)
Lance, Elton W., 125 W. Milton av., Rahway (20)
Landaw, Louis, 631 E. 26th st., Paterson (16)
Landes, Edwin W., Stillwater (19)
Landesman, William, 187 Kearny av., Kearny (7)
Landis, Harry P., Jr., 901 Columbia av., Palmyra(3)
Landshof, Charles A., 50 Glenwood av., Jer. City (9)
Lane, Edgar W., 46 Main st., Bloomsbury (10)
Lane, Thomas F., 145 Garrison av., Jersey City (9)
Lang, Joseph, 111 Market st., Perth Amboy (12)
Lang, Joseph T., 115 Main st., South River (12)
Lang, Louis, 947 E. Jersey st., Elizabeth (20)
Lang, Paul, 32 W. Commerce st., Bridgeton (6)
Lang, Richard E., 463 Passaic av., Passaic (16)
Lang, Richard W., 1003 Park av., Plainfield (20)
Langdon, Benjamin B.,450 Summit av.,Hackens'k(2)
Lange, Louis C., 50 Clifton ter., Weehawken (9)
Langgaard, Charles, City Hospital, Newark (7)
Langston, Junius T., 521 E. Second st., Plainf'd(20)
Lapin, Louis P., 15 Crosswicks st., Bordentown (11)
Lapin, Mathew R., 628 W. State st., Trenton (11)
Larkey, Irving G., 95 Shanley av., Newark (7)
Larossa, Ernest A., 561 Benson st., Camden (4)
Larrabee, Callie H., 10 Irving pl., Summit (20)
Larson, Henry M., 35 Franklin st., Morristown (14)
Larsson, Evert A., N. J. State Hosp., Trenton (11)
Lathrop, Frederic W., 909 Park av., Plainfield (20)
Lathrope, George H., 965 Broad st., Newark (14)
Latona, Joseph A., 78 Main st., Lodi (2)
Laudig, Guy H., 361 Speedwell av., Morris Plains(14)
Laufenberg, Joseph W., 1544 S. Broad st.,Trent'n(11)
Laurusonis, John, 319 W. Broad st., Gibbstown (8)
Lavine, Barney D., 630 N. Clinton av., Trenton (11)
Lavine, Samuel C., 502 Georges rd., N. Br'nsw'k(12)
Lavine, Sidney B., 144 W. State st., Trenton (11)
Law, Harrison E., 397 Prospect av., Hackensack (2)
Lawless, Edward T.,105 Clarewill av.,Up.Montcl'r(16)
Lawner, Ethel G., 25 Kensington av., Jer. City (9)
Lawrence, Elias D., 499 Park av., Paterson (16)
Lawsing, G. Conde, 443 66th st., West New York (9)
Lawther, Boyd M., 1401 Shore rd., Northfield (1)
Lazow, S. Manlius, 199 Main st., Matawan (12)
Leach, John E., 274 Carroll st., Paterson (16)
Leaman, Granville M., 182 N. Grove st., E.Orange(7)
Leaver, Morris H., Quakertown (10)
LeBel, Louis J. B., 165 Grant av., Nutley (7)
Leber, Otto H., 63 Myrtle av., Montclair (7)
Ledden, Lewis J., 1104 Hamilton av., Trenton (11)
Lee, Benjamin F.,Broadway Stevens Bldg.,C'md'n(4)
Lee, John J., 309 Park av., Orange (7)
Lee, Robert E., 24 Great Oak dr., Short Hills (7)
Lee, Thomas B., 622 Cooper st., Camden (4)
Lee, William A., 269 Jewett av., Jersey City (9)
Leeds, Leonard W., 701 Stuyvesant av.,Irvington(7)
Leevy, Carroll M., 543 Bergen av., Jersey City (9)
LeFavor, Dean H., 619 Morgan av., Palmyra (3)
Leff, Abraham, 98 Hackensack st., Wood-Ridge (7)
Leff, Charles O., 5 Elm ct., South Orange (7)
Leff, William A., 299 Clinton av., Newark (7)
Lefkowitz, Jacob H., 445 64th st., West New York(9)
Legato, Samuel F., 432 Palisade av., Cliffside Pk.(2)
Legg, George E., 666 Broadway, Paterson (16)
Leggett, Lindley H., Jr., 330 E. Broad st.,Westf'd(20)
Leggett, Thomas H., Jr., 706 Park av., Plainfield(20)
Lehmacher, Frank, 16 Central av., Lakewood (15)
Lehman, David J., Jr., 192 Roseville av., Newark(7)
Lehmann, Otto, 138 Bath av., Long Branch (13)
Lemay, Albert T., 532 14th av., Paterson (16)
Lemkin, Samuel, 71 Pomona av., Newark (7)
Lemmerz, Willard H.,135 Hack'ns'k st.,Wood-R'ge(2)
Lemmon, Junius M., 137 Belvidere av.,Wash'gton(21)
Lempke, Richard J., 3 Armstrong av., Jer. City (9)
Leon, Maurice J., 387 U. Mountain av., U. M'tcl'r(7)
Leonard, Bernard, 33 W. Union st., Burlington (3)
Leonard, Isaac E., 2842 Atlantic av., Atlantic City(1)
Leonard, Isaac E., Jr., 2842 Atlantic av., Atl. City(1)
Leonard, Lothair L., 615 Asbury av., Asbury Pk.(13)
Leonard, Martha F., 55 N. 5th av., Highland Pk.(12)
Leone, Peter P., 27 Princeton rd., Elizabeth (20)
Lepis, A. Albert, 39 Bentley av., Jersey City (9)
Lepree, Joseph A., 371 Morris av., Elizabeth (20)
Lerman, Frederick, 1024 E. Jersey st., Elizabeth(20)
Lerman, Irving, 1024 E. Jersey st., Elizabeth (20)
Lerman, Samuel, 116 Brightside av.,Pikesv'e,Md.(20)
Lesko, Stephen W., 234 Mt.Pleas't av.,Wallington(2)
Lettiere, Anthony J., 425 E. State st., Trenton (11)
Leuzzi, Darwin A., 2515 Palisade av., Union City(9)
Levendusky, Daniel E., 20 W. Main st.,Rockaw'y(14)
Levin, Jack, 95 W. Main st., Freehold (13)
Levin, Joseph, 831 S. 13th st., Newark (7)
Levin, Murray, 20 Callamore dr., West Orange (7)
Levine, Burton, 31 Lincoln Park, Newark (7)
Levine, David B., 647 Broadway, Paterson (16)
Levine, Edward P., 384 Clinton av., Newark (7)
Levine, G. Irving, 100 Bentley av., Jersey City (9)
Levine, Philip, 61 Lincoln Park, Newark (7)
Levine, Sidney C., 500 Market st., Paterson (16)
Levinsohn, Sandor A., 656 E. 29th st., Paterson (16)
Levinson, David M., 860 S. 12th st., Newark (7)
Levinson, Louis J., 43 S. Pierson rd., Maplewood (7)
Levinson, Reuben, 123 Market st., P. Amboy (12)
Levison, William, 75 Lincoln Park, Newark (7)
Levitas, George M., 199 Fairview av., Westwood (2)
Levitas, Irving M., 199 Fairview av., Westwood (2)
Levitsky, Edward, 767 E. Third av., Roselle (20)
Levy, Abram, 1401 Plainfield av., S. Plainfield (18)
Levy, Anna L., 32 S. Munn av., East Orange (7)
Levy, David, 586 E. 29th st., Paterson (16)
Levy, Herman, 158 Lexington av., Passaic (16)
Levy, Irvin, 222 W. State st., Trenton (11)
Levy, Jack D., 191 Union st., Hackensack (2)
Levy, Julius, 221 S. Harrison st., East Orange (7)
Lewandowski, Edmund E., 2 Smalley ter.,Irv'gt'n(7)
Lewin, Leo, Howard Blvd., Mt. Arlington (14)
Lewis, Alexander, 113 E. Milton av., Rahway (20)
Lewis, Alice B., 1 Gilbert rd., Hohokus (2)
Lewis, Collins E., 219 Seaman st., New Brunsw'k(12)
Lewis, G. Rae, 458 Washington av., Belleville (7)
Lewis, Jacob, 43 Court st., Freehold (13)
Lewis, John F., Jr., 1201 Park av., Hoboken (9)
Lewis, Robert L., Jr.,636Westminster av.,Eliz'b'h(20)
Lewis, Sydney B., 194 W. State st., Trenton (11)
Liccese, Emanuel, 84 Jefferson st., Newark (7)
Lichtenberg, Walter, 309 Kind'rk'm'k rd.,Westw'd(2)
Licks, Frederick C., 64 Scotland rd., South Orange(7)
Liddell, Raymond N., 45 Grant av., Somerville (18)
Lieb, Robert L., 61 Lincoln Park, Newark (7)
Lieb, Saul, 90 Treacy av., Newark (7)
Lieberman, David P.,597 Westmins'r av.,Elizab'h(20)
Lieberman, Milton L., 101 Pershing av.,Roselle P.(20)
Lieberson, Leonard, 20 62nd st., West New York (9)
Lief, Lawrence H., Gatzmer av., Jamesburg (12)
Liegner, Ben, 858 S. 12th st., Newark (7)

Lilien, Bernard B., 1191 Clinton av., Irvington (7)
Lilien, Milton, 1191 Clinton av., Irvington (7)
Lilien, Milton M., 152 Clark st., Hillside (20)
Lima, John G., 292 Broadway, Paterson (16)
Linares, A. Carfi, 208 Market st., Paterson (16)
Lind, Zoltan H., 215 Livingston av., N.Br'nsw'k(12)
Lindroth, Lawrence V., 4525 Boulevard, N.Bergen(9)
Lintz, Sidney Z., 525 Kings Hwy., Swedesboro (8)
Linz, Curt, 456 Franklin av., Nutley (7)
Lione, John G., 20 E. 32nd st., Bayonne (9)
Lipkin, Isadore, 157 W. Main st., Penns Grove (17)
Lippman, Harold, 68 Elizabeth av., Newark (7)
Lippman, Nathan L., 504 Pacific av., Atl. City (1)
Lipshutz, Benjamin, 18 W. 22nd st., Bayonne (9)
Lipshutz, Charles, 820 Avenue C, Bayonne (9)
Lipson, Stanley, 717 N. Wood av., Linden (20)
Lipstein, William, 845 Chancellor av., Irvington (7)
Lipton, Louis, 67 Passaic av., Passaic (16)
Little, Alonzo W., 120 Arlington av., Jersey City (9)
Little, Rufus R., Bergen Pines Hosp., Oradell (2)
Little, William R., 493 W. State st., Trenton (11)
Littwin, Charles, 950 Queen Anne rd., Teaneck (2)
Liva, Arcangelo, P.O. Box 7, Hackensack (2)
Liva, G. Albin, Madison av., Wyckoff (2)
Liva, Paul F., 280 Stuyvesant av., Lyndhurst (2)
Livengood, Baxter A., 64 Cooper st., Woodbury (8)
Livengood, Horace R., 587 Westm'st'r av.,Eliz'b'h(20)
Livingston, Bernard, 30 Park av., Caldwell (7)
Livingston, Elias, 591 Stuyvesant av., Irvington (7)
Livingston, Paul, 299 Main st., East Orange (7)
Livingston, Sydney R., 650 W. Sev'th st.,Plainf'd(20)
Lloyd, Samuel J., 178 W. State st., Trenton (11)
Llull, Gabriel J., 266 Morris av., Springfield (20)
Lobban, Robert B., 61 Gifford av., Jersey City (9)
Lobsenz, Nathan P., 294 Broadway, Paterson (16)
LoBuono, Joseph, 228 60th st., West New York (9)
Locke, Henrik W., 243 W. Main st., Moorestown (4)
Loder, Horace B., 225 E. Commerce st., Bridgeton(6)
Loder, Joseph S., 924 S. 17th st., Newark (7)
Loeb, William A., Veterans Admin., Lyons (18)
Loeser, Lewis H., 188 Clinton av., Newark (7)
Lohman, Herman, 31 Lincoln Park, Newark (7)
Loizeaux, Edward C., 320 E. Seventh st., Plainf'd(20)
Loizeaux, Theodore, 212 E. Seventh st., Plainf'd(20)
Loman, Samuel G., 139 Jefferson av., Cresskill (2)
Lomauro, James R., 184 Lexington av., Passaic (16)
Lomax, Charles L., 417 W. Broad st., Westfield(20)
Lombardi, Frank L., 25 E. Clinton av., Bergenfi'd(2)
Lombardo, Bartlo, 111 Wilson av., Newark (7)
London, Isabel M., 103 N. Fourth av., Highl'd P.(12)
London, Leslie, 120 Lexington av., Passaic (16)
London, Randolph A., 7615 Park av., N. Bergen (9)
London, William, 255 State st., Perth Amboy (12)
Londrigan, Joseph F., 832 Bloomfield st.,Hoboken(9)
Londrigan, Joseph F., II, 832 Bloomf'd st.,Hobok'n(9)
Long, Elias E., 85 W. Front st., Red Bank (13)
Long, John F., 82 Grand pl., Arlington (7)
Long, Miles T., 2150 Boulevard, Jersey City (9)
Long, Pauline A., 22 Livingston av., N.Br'sw'k(12)
Longbothum, George M.,733Watch'g av.,Plainf'd(20)
Longnecker, John E., Jr., Sparta (19)
Longo, James J., 74 Ridge rd., N. Arlington (7)
Longsdorf, Harold E., Bartram av., Mt. Holly (3)
Looloian, Mehran W., White House Station (10)
Lord, C. Donald, 76 W. Ridgewood av., Ridgew'd(2)
Losada, Camella A.,P.O.Box 194,Centr'l Val.,N.Y.(20)
Love, Elizabeth F., Jeanes Hosp., Phila., Pa. (3)
Lovell, John F., 1013 Clinton av., Irvington (7)
Lovett, Irving K., 110 E. Front st., Red Bank (13)
Low, Donald B., 529 Broadway, Paterson (16)
Lowe, Louise, 248 State st., Hackensack (2)
Lowell, Milton E., 434 Summit av., Westfield (20)
Lowenstein, Aaron, 860 S. 11th st., Newark (7)
Lowenstein, Ernest C., 259 W.Milton av.,Rahw'y(20)
Lowenstein, Harry A., 96 Milford av., Newark (7)
Lowrey, James H., 79 Congress st., Newark (7)
Luban, Benjamin, 730 High st., Newark (7)
Luca, Frank, 563 Westwood av., Long Branch (13)
Luca, Mildred O., 563 Westwood av., L. Branch (13)
Lucas, Stanley L., 44 N. Kentucky av., Atl. City (1)
Lucas, W. Fred, 23 W. Broad st., Burlington (3)
Lucent, S. Bell, 2 First av., Little Falls (16)
Lucey, James J., 185 Market st., Perth Amboy (12)
Luczynski, Edward W., 726 Avenue C, Bayonne (9)
Luddecke, Hugh F., 40 Franklin st., Morrist'n (14)
Lufburrow, Charles B., 441 W. Front st.,Plainf'd(20)
Luippold, Eugene J., Jr.,130 Fairv'w av.,Boont'n(14)
Lundblad, Walter E., 75 Prospect st., E. Orange (7)
Luongo, Federico, 212 S. Centre st., Orange (7)
Lupin, Edward E., 930 Boulevard, Bayonne (9)
Luria, Sanford A., 249 Queen Anne rd., Bogota (2)
Lurie, Solomon I., 21 Hillside av., Newark (7)
Lurie, Wolf, 379 Kearny av., Kearny (7)
Lushear, Frank H., Branchville (19)
Lussier, Georges H., Brisbane Center, Farm'gd'e(13)
Lustig, Melvin, 227 Schuyler av., Newark (7)
Lutz, Martin H., 130 W. Fifth av., Roselle (12)
Lutz, William M., 3 Southern Slope dr., Millburn(7)
Lyerly, James M., 815 Park av., Plainfield (20)
Lyght, Charles E., Merck & Co., Rahway (20)
Lynch, Albert E. O., 257 Orange rd., Montclair (7)
Lynch, Donald C., 885 Stuyvesant av., Trenton (11)
Lynch, Edward T., 748 Livingston rd., Elizabeth(20)
Lynch, James F., 1947 Boulevard, Jersey City (9)
Lynch, Maurice M., 46 Anderson st., Hackensack(2)
Lynch, Roland J., Mental Dis. Hosp., Secaucus (9)
Lynn, Irving I.. 2760 Boulevard, Jersey City (9)
Lyon, Archibald, 115 Ridge rd., North Arlington (7)
Lyon, Earl C., 194 E. Commerce st., Bridgeton (6)
Lyons, James V., 333 Park av., Orange (7)
Lyons, Romola L. K.,171 Mead'wbr'k rd.,Englew'd(2)

ASSOCIATE MEMBER

Leach, Morton W., 1616 Pacific av., Atlantic City(1)

M

ACTIVE MEMBERS

Maas, Max A., 329 Clinton av., Newark (7)
Mabee, John R., 24 Center av., Little Falls (16)
MacAlpine, Kenneth B.,500 ChewsLdg.rd.,Had'nf'd(4)
Macaluso, Dominic C., 452 Wash'gton av.,Bellev'e(7)
MacArt, J. Harold, 120 Prospect st.,South Orange(7)
MacArthur, Clymont, 219 Roseville av., Newark (7)
Macaulay, Francis A., 819 Elm av., Teaneck (2)
Macchia, Benjamin J., 358 Arlington av.,Jer.City(9)
MacDermid, Lynden E.,506 Farnsw'h av.,Bord't'n(11)
MacDonald, Edward O., 719 Locust st., RoselleP.(20)
MacGahan, William H., 1 Main st., Butler (16)
MacGregor, Allan W., 379 Ellison st., Paterson (16)

MacGregor, Mary E.C.,242 Fairm'nt av.,Chath'm(14)
MacKellar, James M., 26 E. Clinton av., Tenafly (2)
MacKenzie, Robert A., 501 Grand av., AsburyPk.(13)
Mackes, Claude B., 48 N. Main st., Woodstown(17)
Mackin, John J., 596 Bergen av., Jersey City (9)
Mackler, Harry S., 752 N. Broad st., Elizabeth (20)
Mackler, Meyer E., 627 E. 24th st., Paterson (16)
MacLaren, Philip J., 3 Tenafly ct., Tenafly (2)
Maclay, Joseph A., 239 Broadway, Paterson (16)
MacMillan, C. Wright, 4 Duryea rd., Up.Montcl'r(7)
MacNeal, Perry S., 417 Chester av., Moorestown(3)
Macpherson, Elwood H., 34 Rawley pl., Millburn (7)
Madara, John S., 31 Market st., Salem (17)
Madaras, John S., 870 Avenue C, Bayonne (9)
Maddren, Russell F., 372 Union st., Hackensack (2)
Mader, A. Ivan, Jr., 430 Union st., Hackensack (2)
Madi, Risley J., 735 Montrose st., Vineland (6)
Madison, L. Keith, 358 Pacific av., Jersey City (9)
Maffeo, Carl E., 266 Van Buren st., Newark (7)
Maffongelli, Joseph A., 311 Broadway, Paterson (16)
Magee, Edward S., 201 Wt. Horse Pk., Audubon (4)
Magee, Russell S., 201 Wt. Horse Pk., Audubon (4)
Magee, William P., 1009 Abbott blvd., Palisade (2)
Maggio, George A., 419 Roseville av., Newark (7)
Maggio, Nicholas A., 130 Fleming av., Newark (7)
Maggio, Ross J., 206 Park av., Westfield (20)
Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
Magnes, Max, 555 15th av., Paterson (16)
Magolda, Anthony F., 727 Grape st., Vineland (6)
Magovern, Thomas F., 228 S. Orange av.,S.Orange(7)
Magson, Albert E., 302 S. Main st., Hightstown(11)
Maher, John E., 90 Third av., Long Branch (13)
Mahoney, Francis W., 41 Crescent av.,JerseyCity(9)
Mahoney, Thomas H., 321 Ridge rd., Rutherford (2)
Mahood, Herbert L., 86 Durand rd., Maplewood (7)
Mains, M. Paul, Mercer Hospital, Trenton (11)
Maisel, Irving, 112 Chapman pl., Irvington (7)
Majeski, Henry J., 930 Brunswick av., Trenton (11)
Major, Morton M., 4212 Ventnor av., Atlantic City(1)
Makin, John B., 501 Grand av., Asbury Park (13)
Malatesta, Charles S., 1203 Martine av.,Plainf'd(20)
Maldeis, A. M. K., 117 N. Sixth st., Camden (4)
Malgerl, John, 279 Shepard av., East Orange (7)
Malinowski, John, 554½ Jersey av., Jersey City (9)
Mallison, Herbert, 819 Park av., Plainfield (20)
Mamlet, Alfred M., 33 Johnson av., Newark (7)
Manahan, Daniel V., 55 E. Front st., Red Bank (13)
Mancene, Edward M., 225 Main st., Little Ferry (2)
Mancusi-Ungaro, Alvin P.,268 Mt.Pr'p't av.,N'w'k(7)
Mancusi-Ungaro, Harold, 480 Grove st., Montcl'r(7)
Mancusi-Ungaro, Lodovico, 156 M.Pr'p't av.,N'w'k(7)
Mandell, Sidney N., 313 Monastery pl., Union City(9)
Manette, Milton, 535 41st st., Union City (9)
Manfro, Gerard J., 35 Newark st., Newark (7)
Mangogna, Philip, 334 Barclay st., Perth Amboy(12)
Mangone, Edith, 174 Clinton av., Jersey City (9)
Manly, Thomas E., 390 Park av., Paterson (16)
Mann, Jacob J., 255 State st., Perth Amboy (12)
Manno, Peter D., 843 Boulevard, Bayonne (9)
Manrodt, Kurt, Jr.,N'w'k-Pompt'n Tpk.P'pt'n P.(16)
Mansfield, Richard, 435 59th st., West New York(9)
Marcarian, Henry G., 917 Cooper st., Camden (4)
Marchione, Nicholas E., 105 S. East av., Vineland(6)
Marcus, Bernard, 6 S. Clark av., Somerville (18)
Marcus, Donald, 647 Stuyvesant av., Irvington (7)
Marcus, Kurt, 85 Bowers st., Jersey City (9)
Margaretten, Edward I., 280 Hobart st.,P.Amboy(12)
Margolin, Samuel J., 1012 80th st., North Bergen (9)
Margolis, Alfred, 736 Sanford av., Newark (7)
Margulies, Charles, 49 Park dr., Nutley (7)
Marin, Robert B., 85 Park st., Montclair (7)
Marini, Dominick, 40 Henry st., Passaic (16)
Marino, Benjamin, 14 Llewellyn pl., N.Br'nsw'k(12)
Mark, Harold I., 1022 Garrison av., Teaneck (2)
Mark, Harry B., 600 Elm ter., Riverton (3)
Mark, Joseph S., 102 Green st., Woodbridge (12)
Markel, Albert G., 450 Park av., Paterson (16)
Markley, Luther A., Holy Name Hosp., Teaneck (2)
Markowitz, Benjamin B., 2749 Boulevard,Jer.City(9)
Markowitz, Irwin B., 88 Gifford av., Jer. City (9)
Markowitz, Isidor, Army (5)
Markowitz, Louis, 380 Park av., Paterson (16)
Marks, Zelda I., 202 Clinton av., Newark (7)
Marlett, Neumann C., 230 Greenw'h st.,Belvid're(21)
Marone, Carmine R., 752 Newark av., Elizabeth (20)
Maroney, James H., 129 Summit av., Summit (20)
Marquis, Dean W., 144 Harrison st., East Orange(7)
Marquis, W. James, 12 Hawthorne av., E. Orange(7)
Marra, Rocco S., 221 Park av., Orange (7)
Marrocco, William A., 445 Park av., Paterson (16)
Marshall, Frank A., 2202 Palisade av.,Weeh'wk'n(9)
Marshall, H. Donald, 707 N. Indiana av., Atl. City(1)
Martin, Francis E.,Lake rd.,Box83,Mor'st'n,R.D.1(21)
Martin, Leonard J., Box 431, Asbury Park (13)
Martin, Theodore, 577 Lincoln av., Glen Rock (16)
Martin, William E., 110 Claremont pl., Cranford(20)
Martland, Harrison S., City Hospital, Newark (7)
Marts, George H., 956 Park av., Plainfield (20)
Marucci, Horace D., 298 Elmwood av., Maplewood(7)
Marvel, Peter H., 2216 Shore rd., Northfield (1)
Marvin, Dorothy H., 51 Livingston av.,N.Br'sw'k(12)
Marx, Frederick J., 539 Kinderkam'k rd.,River E.(2)
Mascara, Gaetano A., 540 Wood st., Vineland (6)
Masciocchi, Thomas A., 316 Park av., Orange (7)
Mason, Alvin S., 26 Olive st., Salem (17)
Mason, James H., 1616 Pacific av., Atlantic City (1)
Mason, Stuart A., 756 E. Ridgewood av., Ridgew'd(2)
Mason, Virgil A., 144 Harrison st., East Orange (7)
Massengill, Fulton, 233 Heywood av., Orange (7)
Mast, Joseph E., 1270 Magie av., Elizabeth (20)
Masterson, John F., 98 Myrtle av., Irvington (7)
Mastroianni, Frank M., 634 Sherm'n av.,Ros'leP.(20)
Mastromonaco, Joseph D., 790 Avenue C,Bayonne(9)
Masucci, Alberico, 128 Carroll st., Paterson (16)
Matheke, George A., 29 E. Wood st., East Orange(7)
Matheke, Otto G., 328 Sussex av., Newark (7)
Matheke, Otto G., Jr., 328 Sussex av., Newark (7)
Matheson, Gilchrist E., 144 Harrison st.,E.Orange(7)
Mathews, Raymond H., 186 South st., Morrist'n(14)
Mathews, William J., 938 Hudson st., Hoboken (9)
Matthews, Clifford B., 1180 Raymond Blvd.,New'k(7)
Matthews, Leonard M., 655 Main av., Passaic (16)
Matthews, William, 139 Broad st., Red Bank (13)
Matthews, William F., 180 Walnut st., Montclair(7)
Matturri, Dominick A., 81 Gifford av., Jersey City(9)
Maturi, Vincenzo E., 814 Boulevard, Bayonne (9)
Mauer, Richard E., 116 Ridge rd., Rutherford (7)
Maurer, K. Virginia, 16 Prospect rd., Livingston (7)
Maurer, Martha E., 153 Mountain av., Westfield (20)
Mauriello, Dominic, 2630 Boulevard, Jersey City (9)
Maver, William W., N. J. Trust Bldg., Jer. City (9)
May, Ernst A., 52 DeForest av., Summit (7)
Mayhew, Charles H., 329 Pine st., Millville (6)
Mazur, Edward F., 540 Bridgeboro rd., Riverside(3)
Mazur, Stephen H., 557 Grove st., Irvington (7)
Mazzei, Armando, 282 Liberty st., L. Branch (13)
Mazzotta, Samuel, 5806 Pacific av., Wildwood (5)
McAfoos, Louis G.,Jr.,346 Richey av., Collingsw'd(4)
McAlpine, Paul, 129 Summit av., Summit (20)
McAuliffe, Vincent, 910 Queen Anne rd., Teaneck(2)
McAveney, Thomas F. G., 58 N. Munn av., E. Or.(7)
McBride, Andrew F., Jr., 655 Broadway,Paterson(16)
McCaffrey, Wallace T., 82 Highw'd ter.,Weeh'k'n(9)
McCall, Jesse, 9 Linwood av., Newton (19)
McCallion, Wm. H., 722 Westminster av.,Elizab'h(20)
McCallum, Arthur S., 213 Clements Br.rd.,Bar'gt'n(4)
McCarroll, E. Mae, 59 Hillside pl., Newark (7)
McCarron, James A., 727 Avenue C, Bayonne (9)
McCarthy, Arthur M., 2772 Federal st., Camden (4)
McCarthy, George L., 506 Union av., Paterson (16)

McCarthy, John J., 1001 79th st., North Bergen (9)
McCarthy, William P., 1203 Parkside av.,Trent'n(11)
McCauley, Francis J., 140 Roseville av., Newark (7)
McClintock, Elsie, 1439 Maple av., Hillside (20)
McConaghy, Thomas P.,10th & Cooper sts.,Camd'n(4)
McConville, Edward B.,1213 Hamilt'n av.,Trent'n(11)
McCormack, Frank C., 95 Tenafly rd., Englewood(2)
McCormick, James E., 775 Elizabeth av., Newark(7)
McCormick, Wm. H., Jr., 266 Market st.,P.Amboy(12)
McCracken, Josiah C., Jr.,16 S.Suffolk av.,Ventnor(1)
McCreight, David W., N.J. State Hosp.,Marlboro(13)
McCroskery, Hamilton M.,471 N.Arl'gt'n av.,E.Or.(7)
McCroskery, James H., 471 N. Arl'gt'n av.,E. Or. (7)
McCue, John B., 118 Lenox av., Pompton Lakes(16)
McCurdy, Robert G.,74 W.Highland av.,Atl.Hlds.(13)
McDermott, Vincent T., 509 State st., Camden (4)
McDonald, Andrew, Richmond av., P. Pleasant(15)
McDonald, John, Jr., 322 Fifth st., Belvidere (21)
McDonald, Richard J., 80 Park av., Paterson (16)
McDonnell, George J., 80 W. Main st., Freehold (13)
McFeely, Percy R., 242 Palisade av., Bogota (2)
McGahn, Joseph, 18 S. Stenton pl., Atlantic City (1)
McGeary, John A., 31 Lincoln Park, Newark (7)
McGee, Hugh E., 117 Cedar lane, Teaneck (2)
McGeehan, Stanley M., 6505 Atlantic av., Ventnor(1)
McGinn, William J., 1913 Westfield av.,Scotch P.(20)
McGlade, Thomas H., 1225Walnut av.,W.Col'gsw'd(4)
McGovern, John F.,Jr.,24Liv'gston av.,N.Br'sw'k(12)
McGovern, Patrick J., 3284 Boulevard, Jer. City (9)
McGreevey, Harold, 314 Brighton av., Spring L.(13)
McGuigan, Francis A., 212 N.Warren st.,Trenton(11)
McGuinn, William B., 10 N. Ridgewood rd., S. Or.(7)
McGuire, John J., 2 Gould av., Newark (7)
McGurl, Francis J., 763 Broad st., Newark (7)
McIlveen, Marion, 260 Godwin av., Ridgewood (2)
McKeever, William J., 990 Summit av., Jer. City(9)
McKelvie, Julius C., 55 Rockwell av., L. Branch(13)
McKeown, George H. C.,68 Mont'ne st.,Br'kl'n,N.Y.(7)
McKiernan, Robert L., 75Liv'gston av.,N.Br'sw k(12)
McKim, William F., 317 Roseville av., Newark (7)
McKinley, C. Scott, Bakelite Corp., Bd. Brook (18)
McKinstry, John W., Railroad av., Jamesburg (12)
McLane, A. Donald, 498 Engle st., Englewood (2)
McLaughlin, Thomas F.,19 Durham st.,Metuc'n(12)
McLaughlin, Wm. B., 120 Branch Br'k dr.,Bel'v'e(7)
McLean, Hugh A., 414 61st st., West New York (9)
McLellan, George A., 19 Hawthorne av., E. Or. (7)
McLeod, Harry J., 71 Forest rd., Tenafly (2)
McLoughlin, John W., 34 W. 32nd st., Bayonne (9)
McMahon, Bernard C., 15 James st., Morristown (14)
McMurtrie, William A., 20 Franklin st., Morrit'n(14)
McPherson, Malcolm E.,141Di'm d Br.av.,H'wth'e(16)
McTague, Robert S., 37 E. Wash'gt'n av.,Atl.Hd(13)
McVay, Edward A., 234 Lafayette st., Newark (7)
McVeigh, Charles J. D., Main st., Stanhope (19)
McWhorter, John E., 247 Mountain rd., Englew'd(2)
McWilliams, Charles E., Church st., Blackwood (4)
Means, Paul B., N. J. State Hosp., Trenton (11)
Mearin, Robert J., 24 Porter pl., Montclair (7)
Mears, William G., 216 Hillside av., Leonia (2)
Mechanik, Harvey K., 121 E.Seventh st.,Plainf'd(20)
Mecray, Paul M., 405 Cooper st., Camden (4)
Mecray, Paul, Jr., 405 Cooper st., Camden (4)
Meehan, George E., 117 Mercer st., Jersey City (9)
Meehan, James S., Jr., 85 W. Main st.,Bergenfield(2)
Meehan, Martin M., 339 Washington av.,Bellev'e(7)
Meeker, John L., 6 De Barry pl., Summit (20)
Meer, Nadhim E., 338 Park av., Paterson (16)
Megibow, Harold J., 82 W. Main st., Ramsey (2)
Meier, William U., 1062 Ringwood av., Haskell (16)
Meineke, William C., Jr., 820 Chestnut st.,Roselle(20)
Meinhard, Fred, 154 Van Buren st., Newark (7)
Meinzer, Martin S., 147 Market st., Perth Amboy(12)
Meisel, David B., 818 S. 12th st., Newark (7)
Mele, Vincent, 268 Prospect st., South Orange (7)
Mellen, Stanley H., 1 Park pl., Bloomfield (7)
Meloney, Lester F., 156 Second st., Clifton (16)
Meltzer, Louis, 837 Avenue C, Bayonne (9)
Melvin, Daniel G., N. J. State Hosp.,Greyst'e P.(14)
Meneve, Alfred D., 320 Broadway, Paterson (16)
Menge, Carl H., 236 Washington st., Toms River(15)
Menk, Paul E., 31 Lincoln Park, Newark (7)
Mensch, Harvey G., 1117 Mary st., Elizabeth (20)
Merendino, Anthony G., 1616 Pacific av.,Atl. City(1)
Merk, Anthony, 79 N. Ninth st., Newark (7)
Merkelbach, Walter P., 288 Broad st., Bloomfield (7)
Merliss, Eugene, 299 Clinton av., Newark (7)
Merliss, Harry, 972 Main st., Hackensack (2)
Merlo, Francis A., 210 Murray st., Elizabeth (20)
Merlo, Francis V., 33 Prince st., Elizabeth (20)
Mermod, Camille, 15 Washington st., Newark (7)
Merrick, Evelina, 142 Clinton av., Newark (7)
Merrill, Edwin D., Green st., Milford (10)
Mersch, Marcel A., 680 Broad av., Ridgefield (2)
Merselis, John G., 110 Irvington av., S. Orange (7)
Messina, Thomas, 128 Park av., East Orange (7)
Messinger, Samuel, 31 Roosevelt av., Carteret (12)
Metsky, Joseph, 777 High st., Newark (7)
Metz, Henry, 445 Prospect av., Hackensack (2)
Metzer, Freeman W., 428 Fairview st., Riverside (3)
Meurlin, Alfred, 144 Harrison st., East Orange (7)
Meyer, Eugene A., 427 Cooper st., Camden (4)
Meyer, George P., 410 Haddon av., Camden (4)
Meyer, Howard M., 400 Maple Hill dr.,Hackens'k(2)
Meyers, Francis R., 604 E. 28th st., Paterson (16)
Meyerson, Noah, 428 59th st., West New York (9)
Michell, George E., 221 High st., Hackettstown (21)
Michelson, Henry, 675 E. 24th st., Paterson (16)
Mick, Edwin C., 46 S. Burnett st., East Orange (7)
Mickewich, Stephen A., 817 Avenue C, Bayonne (9)
Miele, Frank A., 314 Carr av., Keansburg (13)
Migliori, Angelo, 531 S. Clinton av., Trenton (11)
Milanesi, Armand M., 614 79th st., N. Bergen (9)
Milano, Cesare A., 1 S. Brighton av., Atlantic City(1)
Miller, Charles E., 228 Main st., Hackettstown (21)
Miller, Earle K., 2512 Nottingham way, Trenton(11)
Miller, Eugene L., 63 Baldwin av., Newark (7)
Miller, George M., 288 Elm av., Rahway (20)
Miller, Gerald H., N. Main st., Cranbury (11)
Miller, Herman P., 815 S. 12th st., Newark (7)
Miller, I. Irwin, 675 Sanford av., Newark (7)
Miller, Joseph A., 364 Prospect st., S. Orange (7)
Miller, Nathan, 838 S. 12th st., Newark (7)
Miller, Ralph, 32 Johnson av., Newark (7)
Miller, Raymond E., 192 W. State st., Trenton (11)
Miller, Robert M., 36 Woodland av., Summit (20)
Miller, S. David, 90 Carroll pl., N. Brunswick (12)
Miller, Samuel R., 407 S. Main st., Pennington (11)
Miller, William H., 7 Dickinson st., Woodstown (17)
Milliser, Estelle T., 126 N. Euclid av., Westf'd (20)
Mills, Charles S., 106 Lippincott av., Riverton (3)
Mills, Clifford, 36 Maple av., Morristown (14)
Milnamow, Paul, 318 Cooper st., Camden (4)
Minck, Peter, Jr., East Saddle River rd.,Saddle R.(2)
Minier, Carl L., 226 N. Park st., East Orange (7)
Miningham, William D., 18 Hedden ter., Newark (7)
Minnefor, Charles A., 1164 S. Orange av., S. Or.(7)
Mintz, Alvin R., 32 Maple av., Morristown (14)
Mintz, Julius, Sycamore av., North Plainfield (18)
Mishler, Jay E., 1616 Pacific av., Atlantic City (1)
Misko, Albert, 117 Westervelt av., N. Plainf'd(18)
Missonellie, William, 404 Lafayette av., H'wt'ne(16)
Mitchell, Augustus J., 270 Montclair av., Newark (7)
Mitchell, Charles H., 1100 W. State st., Trenton (11)
Mitchell, Charles R., 311 Broadway, Paterson (16)
Mitchell, Walter L., Jr., 161 Roseville av.,Newark(7)
Mitchell, Willis B.,Holly Cranm'r Man'r,Toms R.(15)
Mitskas, Theodore V.J.,1329Greenw'd av.,Tr'nt'n(11)
Mockett, Walter W., 55 E. Magnolia av., Mayw'd(2)
Modarelli, Walter H., 1505 Central av., Union City(9)

Modeski, Chester J., 306 Roseville av., Newark (7)
Modrys, Walter F., 714 Palisade av., Cliffside Pk.(2)
Moeckel, Clarence W., 63 S. Fullerton av.,Montcl'r(7)
Mohair, John P., N. J. State Hosp., Marlboro (13)
Mohr, Frank L., 560 Morris av., Summit (20)
Moir, John A., 18 N. Main st., Cape May Ct. H. (5)
Molitch, Matthew, 705 Pacific av., Atlantic City(1)
Monaco, Dante P., 436 Roseville av., Newark (7)
Monaco, Saverio A., 293 Camden st., Newark (7)
Monaloy, Morris A., 414 Passaic av., Passaic (16)
Monica, Louis A., 875 Boulevard, Bayonne (9)
Monosson-Friedland, Ida, 200 N. East av.,Vinel'd(5)
Monte, Thomas D., 213 Park st., Montclair (7)
Moolten, Sylvan E., 103 N. Fourth av.,Highl'd P.(12)
Moon, Dabney vonK., 706 Park av., Plainfield (20)
Moore, Dean C., 391 Highland av., Orange (7)
Moore, J. Leonard, 59 Westcott rd., Princeton (11)
Moore, Ralph L., 127 N. Broad st., Woodbury (8)
Moore, William J., 10 N. Olden av., Trenton (11)
Mores, Herbert R., 321 Union st., Hackensack (2)
Moress, Edward J., 1524 Maple av., Hillside (7)
Morgan, Browne, 32 Benson st., Bloomfield (7)
Morgenstern, Mates, 184 Liv'gston av.,N.Br'sw'k(12)
Moriarty, John F., 723 Washington st., Hoboken(9)
Morici, Theodore, 80 Howe av., Passaic (16)
Moriconi, Albert F., 438 Hamilton av., Trenton (11)
Morley, Grace C., 1218 Hudson st., Hoboken (9)
Morrill, James P., Jr., 310 Broadway, Paterson (16)
Morris, Carlyle, Spring st., Metuchen (12)
Morris, David G., 11 W. 26th st., Bayonne (9)
Morris, Karl E., 648 E. Broad st., Westfield (20)
Morris, Nathan, 607 E. Second st., Plainfield (20)
Morris, Thomas M., 505 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Springfield (20)
Morrison, Frederick H., 61 High st., Newton (19)
Morrow, J. Lloyd, 197 Passaic av., Passaic (16)
Morton, Thomas V., Jr., 263 Bloomf'd av.,Bl'mf'd(7)
Moscoe, Harry A., 542 Broadway, Paterson (16)
Moss, Jack W., Maple av., Wyckoff (2)
Mott, Joseph E., 426 Park av., Paterson (16)
Motzenbecker, Peter F., 69 S. Pierson rd.,M'plew'd(7)
Motzenbecker, William J., 16 Milford av., New'k(7)
Mountford, William E., 217 N. War'n st.,Tr'nt'n(11)
Movelle, John, 840 River rd., Fair Haven (13)
Muccia, John J., 7 Tonnele av., Jersey City (9)
Mueller, George H., 102 Summit av., Jersey City (9)
Mulberg, Harry, 769 Kearny av., Arlington (7)
Mulford, William P., 202 Warren st., Beverly (3)
Muller, Frederick L., 511 Broad st., Carlstadt (2)
Mulligan, Edward W., 81 Shrewsb'y av.,Red B'k(13)
Mulligan, Luke A., 230 Fort Lee rd., Leonia (2)
Mulvihill, William J., 275 Boulevard, Bayonne (9)
Munro, Jeannette, 2 Queenston pl., Princeton (11)
Murn, Charles J., 48 Smith st., Paterson (16)
Murphy, Herschel S., 320 Chestnut st., Roselle (20)
Murphy, James A., 312 Bellevue av., Trenton (11)
Murphy, James M., 2757 Boulevard, Jersey City (9)
Murphy, Leo J., 1814 West st., Union City (9)
Murphy, Thomas W., Jr., Navy (7)
Murray, Clifford K., 5901 Ventnor av., Ventnor (1)
Murray, Edward F., 140 Roseville av., Newark (7)
Murray, Edwin N., 130 N. Broadway, Camden (4)
Murray, Harrold A., 624 Mt. Prospect av.,New'k(7)
Murray, Norman L., 129 Summit av., Summit (20)
Murto, Thomas V., 117 Buckingham av., Trenton(11)
Musetto, Carmelo A., 135 Cornelia st., Boonton (14)
Mustermann, Otto H., 303 48th st., Union City (9)
Musulin, Nicholas R., 514 Cooper st., Camden (4)
Muttart, George W., 2521 Boulevard, Jersey City(9)
Mutter, Alfred A., 75 Beech st., Arlington (9)
Myatt, Leslie E., 98 N. Pearl st., Bridgeton (6)
Myers, Norman V., 136 Engle st., Tenafly (2)

ASSOCIATE MEMBERS

Mahadeen, Onver, 51 Union av., Paterson (16)
Mann, Hillard, 431 Washington av., Belleville (7)
Marchigiano, Anthony T.,310 Roseville av.,New'k(7)
Mason, James H.,IV,52 Revere rd.,Drexel Hill,Pa.(1)
Masterson, John E., 99 Brookdale G'd'ns,Bl'mf'd(7)
Mattioli, Eli D., Harding Highway, Landisville (1)
Matyjasik, Frank M., 518 Centre st., Trenton (11)
McCarthy, Joseph F., 615 Beatty st., Trenton (11)
Mendelson, Max, 72A Brookdale G'd'ns, Bl'mf'd (7)
Midura, Peter, 116 Prospect st., Ramsey (2)
Miller, Bernard J., 75 Raritan av., Highl'd Pk.(12)
Miller, Howard B., 14-18 Chandler dr.,Fair Lawn(16)
Miningham, William D.,Jr.,18 Hedden ter., New'k(7)
Moog, Charles R., 208 Walton st., Ridgewood (16)
Mosig John J.,Asbury Vet. Garden Apts.,Belmar(13)
Murphy, George E., 263 Franklin av., Ridgew'd (16)
Muster, William J., 525 E.Ridgew'd av.,Ridgew'd(16)

N

ACTIVE MEMBERS

Naame, John M., 8014 Monmouth av., Margate C.(1)
Nacca, Carl A., 46 Cleveland st., Orange (7)
Naclerio, Amedeo, 207 Hackens'k st.,Wood-Ridge(2)
Nadel, Charles I., 1013 Clinton av., Irvington (7)
Nafash, Shafeek, 1117 16th st., North Bergen (9)
Nafey, Herbert W., 51 Livingston av., N.Br'sw'k(12)
Naidorff, Saul A., 421 W. Seventh st., Plainfield (20)
Napoliello, Vincent, 125 Clifton av., Newark (7)
Nappi, Pasquale E., 433 Mt. Prospect av., Newark(7)
Nash, Alexander E., 30 Forrest av., Verona (7)
Nash, Herman S., 865 S. 11th st., Newark (7)
Nataro, Jerome D., Army (7)
Nataro, Joseph, 172 Littleton av., Newark (7)
Nataro, Maurice, Nichols Gen. Hosp.,Louisv'e,Ky.(7)
Nathanson, Norman, 489 Broadway, L. Branch (13)
Naulty, Charles W., Jr., 403 High st.,P.Amboy(12)
Navazio, Attillo, 29 DeHart st., Morristown (14)
Nayfield, Ronald C., 990 S. Broad st., Trenton (11)
Neander, David G., 57 Chestnut st., Salem (17)
Neibrief, Milton N., 1 Johnson av., Newark (7)
Neiderhoffer, Sydney L., 469 Broadway,L.Branch(13)
Nelson, Clifford H., 200 Isabella av., Irvington (7)
Nelson, Francis B., 275 Orchard st., Westfield (20)
Nelson, Harry, 36 Lupton av., Woodbury (8)
Nelson, Richard A., 763 Broad st., Newark (7)
Nemiroff, Nathan, 348 Kinderkamack rd.,Oradell(2)
Nemirow, Martin, 162 Lexington av., Passaic (16)
Nemzek, William P. B., 8 Hedden ter.,N.Arl'gton(7)
Nesbitt, Elizabeth, N. J. Train'g Sch'l, Little F'ls (16)
Netz, Lester W., 210 Main st., Hackensack (2)
Neumann, Alfred, 432 Washington av., Linden (20)
Neville, Robert J., 547 Main st., Hackensack (2)
Nevins, Thomas F., Jr., 105 Linden av., Westf'd(20)
Nevius, John K., Jr., 1165 Park av., Plainfield (20)

Nevius, William B., 572 Park av., East Orange (7)
Newbury, Graham C., 234 Summit av., Summit (20)
Newcomb, Marcus W., Browns Mills (3)
Newman, Grace T., 339 Grove st., Montclair (7)
Newman, Julius, 318 Highland rd., S. Orange (7)
Newmeyer, Joseph, 47 S. 27th st., Camden (4)
Ney, J. Marshall, 443 Baldwin rd., Maplewood (7)
Nichols, Joseph E., 144 Harrison st., E. Orange (7)
Nickman, E. Harrison, 1616 Pacific av., Atl. City (1)
Nicol, Lorenz C., 360 Larch av., Bogota (2)
Nicola, Toufick, 96 Gates av., Montclair (7)
Nieman, Solomon Z., 191 Liv'gston av.,N.Br'sw'k(12)
Niemiera, Alexander K., 509 State st., P. Amboy (12)
Niemtzow, Frank, 55 E. Main st., Freehold (13)
Nimaroff, Harold, 152 Market st., Passaic (16)
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth (20)
Noll, Louis, 1383 Clinton av., Irvington (7)
Nonziato, Frank A., 50 Centre st., Trenton (11)
Noone, Thomas A., 416 Broadway, Camden (4)
Normand, Alphonse F., 267 High st., P. Amboy (12)
Norton, James F., 58 Kensington av., Jersey City (9)
Notkin, Meyer, 559 Broadway, Paterson (16)
Novak, John G., 111 Clinton av., Newark (7)
Novello, Joseph A., 641 Second av., Elizabeth (20)
Novich, Max, 1484 Liberty av., Hillside (7)
Nowak, Emil, 738 Market st., Paterson (16)
Nussbaum, Harvey E., 695 Clinton av., Newark (7)
Nussbaum, Joseph, 321 Elmora av., Elizabeth (20)
Nussbaum, Nathan, 237 Lakeview av., Clifton (16)
Nutzel, Leon P., Army (7)
Nuzzolo, Charles A., 400 Park av., Paterson (16)
Nyiri, William A., 32 Johnson av., Newark (7)
Nyvall, Pierre J., 9 Maple av., Barnegat (15)

ASSOCIATE MEMBERS

Narrett, Sidney, 140 Passaic av., Passaic (16)
Nicas, Allen M., 450 Broadway, Long Branch (13)
Noble, Paul R.,Middlesex Gen. Hosp.,N.Brunsw'k(12)
Novak, Edward J., 61 Green st., Woodbridge (12)

O

ACTIVE MEMBERS

Oberlander, Gertrude, 866 S. 13th st., Newark (7)
Obert, J. Edwin, Main st., New Egypt (15)
O'Brian, Dennis M., 154 Lexington av., Passaic (16)
O'Brian, E. Raymond, 831-B E. Front st.,Plainf'd(20)
O'Brian, Jeremiah H., 661 Main av., Passaic (16)
O'Brien, Edwin J., Jr.,733 Watchung av.,Plainf'd(20)
O'Brien, John R., 174 Bowers st., Jersey City (9)
Ockene, Abraham, 2415 Palisade av., Union City (9)
O'Connell, James J., 116 Liv'gston av.,N.Br'sw'k(12)
O'Connell, William, 87 Clifton ter., Weehawken (9)
O'Connor, Bernard A., 47 Central av., Newark (7)
O'Connor, Dennis F., 27 S. Kingman rd., S. Or. (7)
O'Connor, John J., 2124 New York av.,Union City(9)
O'Connor, Michael J., 98 Shanley av., Newark (7)
O'Crowley, Clarence R., 31 Lincoln Park, Newark(7)
Oesterreicher, Desider, 427 Bergen av., Jer. City (9)
Oestreicher, Harry, Picatinny Arsenal, Dover (14)
Offenkrantz, Freder'k M., St. Joseph's H.,Pat'rs'n(16)
Offenkrantz, William C., 121 Vroom st., Jer. City(9)
Ogden, Andrew E., 1829 Greenwood av., Trenton(11)
Ogden, Michael A., 20 Grove st., Passaic (16)
O'Grady, Michael J., 330 Washington av.,Bellev'e(7)
Okin, Irving, 165 Passaic av., Passaic (16)
Olini, Joseph J., 30 W. Market st., Newark (7)
O'Lini, Louis J., 30 W. Market st., Newark (7)
Olivo, Matthew, 419 Cooper st., Camden (4)
Olpp, John L., 49 Ivy lane, Tenafly (2)
Olson, John A., 19 Holly st., Cranford (20)
O'Neill, Charles L., 11 N. Seventh st., Newark (7)
O'Neill, Charles L., Jr., 671 Broad st., Newark (7)
O'Neill, Joseph F., 41 E. Broad st., Hopewell (11)
Onorato, Vincenzo R., 66 Christopher st.,Montcl'r(7)
Opdyke, Gordon M., 52 Claremont av., Verona (7)
Openchowski, Mieczyslaw,399Mt.Prosp't av.,N'w'k(7)
Opfermann, John L., 167 Bay av., Highlands (13)
Opper, Philip, 606 E. 26th st., Paterson (16)
Oram, Joseph H., 495 Broadway, Paterson (16)
Oransky, Marvin, 10 38th st., Irvington (7)
Oren, Hyman, 74 Perry st., Park Ridge (2)
Orloff, Samuel, 59 Girard pl., Newark (7)
Ormsby, Thomas J., 1180 Raymond blvd., Newark(7)
Ornaf, I. Edward, 1145 Thurman st., Camden (4)
O'Rourke, James J., 871 Stuyvesant av., Trenton(11)
Orris, Harold J., 80 Chancellor av., Newark (7)
Ortolano, James J., 911 Washington st., Hoboken(9)
Orton, Foster, 196 Elm av., Rahway (20)
Orton, Henry B., 224 Delavan av., Newark (7)
Orton, Stuart, 196 Elm av., Rahway (20)
Osborn, A. Downey, 415 Fourth av., Belmar (13)
Osborn, Edward G., 3194 Alabama rd., Camden (4)
Ostrowski, Sigismund J., 265 Broad st., Bloomfl'd(7)
O'Sullivan, John R., 11 Quincy av., Arlington (9)
Ott, Franklin B., 999 Clinton av., Irvington (7)
Outwin, Richard N., 46 Maple st., Maplewood (7)
Owen, Philip, 973 Salem rd., Union (20)
Ozier, Charles W., 223 Autumn st., Passaic (16)

ASSOCIATE MEMBERS

O'Connor, John P., 984 Queen Anne rd., Teaneck (2)

P

ACTIVE MEMBERS

Pacicco, Michele, 609 Pavonia av., Jersey City (9)
Padden, Aloysius F., 335 Orchard ter., Bogota (2)
Paddock, Royce, 965 Broad st., Newark (7)
Padney, Edward V., 452 Jersey av., Jersey City (9)
Padovano, Joseph, 517 Roseville av., Newark (7)
Pagano, Peter, 324 Franklin av., Ridgewood (2)
Pagliughi, John J., 1915 Palisade av., Union City(9)
Paisley, Ellwood S., 501 Wt. Horse Pk.,Had'nHts.(4)
Palazzo, William L., Holy Name Hosp., Teaneck (2)
Palin, George, 27 A Wavecrest av., Winfield (20)
Palladino, Alessandro, 86 W. Com'rce st.,Br'get'n(6)
Pallen, Conde deS., 6 Passaic st., Rochelle Pk. (2)

Palma, Nicholas, 20 Hillside av., Glen Rock (16)
Palmer, Francis R., 220 Lexington av., Passaic (16)
Palmer, Harris H., 6 Willow Gr.Pkwy.,Westfl'd(20)
Palmer, Henry S., 128 Court st., Newark (7)
Palmeri, Anthony, 111 Chelsea rd., Clifton (16)
Palmisano, Vincent S., 13 W. 6th av., Runnemede(4)
Palumbo, Vincent A., 22nd & Blvd., Kenilworth (20)
Panigrosso, Louis R., 455 Lawrie st., P. Amboy (12)
Panitch, William, 90 Baldwin av., Newark (7)
Pannell, Walter L., 100 Evergreen pl., E. Orange (7)
Pannullo, John N. P., 365 Roseville av., Newark (7)
Pansy, Abraham A., 12 Jackson st., South River (12)
Pantaleone, Joseph, 504 Hamilton av., Trenton (11)
Panzer, Norman, 615 High st., Newark (7)
Papera, John J., 8 Washington pl., Caldwell (7)
Parell, George C., 275 S. Seventh st., Newark (7)
Parent, Sol, 89 Lincoln Park, Newark (7)
Paris, William, 518 E. 25th st., Paterson (16)
Parker, James W., 175 Shrewsbury av., R. Bank(13)
Parker, John E., 385 Park av., Orange (7)
Parker, Paul, 72 N. Clinton av., Trenton (11)
Parkes, Morey, 33 High st., Orange (7)
Parry, Allen A., 54 Green av., Madison (14)
Parry, Antoinette R., 54 Green av., Madison (14)
Parry, Oliver K., 601 Bangs av., Asbury Park (13)
Parsonnet, Aaron E., 3 Madison av., Newark (7)
Parsonnet, Eugene V., 89 Lincoln Park, Newark (7)
Pascall, Thomas M., 197 Lincoln av., Newark (7)
Pasquariello, Peter, Totowa rd., Totowa (16)
Pasternack, Elroy, Barry Gardens, Passaic (16)
Pastore, Mario, 1925 Pacific av., Atlantic City (1)
Patella, Fulvio, 324 Broadway, Paterson (16)
Patten, John, West Cliff st., Somerville (18)
Patterson, Isaac N., 26 Station av., Westville (8)
Patti, Frank A., 241 Broad av., Leonia (2)
Patton, Paul B., 3 Winding Way rd., Morris P. (14)
Pattyson, Ralph A., 144 Harrison st., East Orange(7)
Paul, Abraham, 4901 Atlantic av., Ventnor (1)
Paul, George A., 788 Lyons av., Irvington (7)
Paul, H. Carl, 30 Westville av., Caldwell (7)
Pauly, Arthur N., 297 W. Summit st., Somerville (18)
Pauncz, Arpad, Veterans Administration, Lyons(18)
Pavia, John R., 48 Mountainview av., East Orange(7)
Payne, Douglas, Cooper Hospital, Camden (13)
Payne, Guy, Jr., 56 S. Prospect st., Verona (7)
Peacock, Arthur B., 201 E. Main st., Moorestown(3)
Pearl, Sydney S., 837 Park av., Elizabeth (20)
Pearlstein, Frank, 325 60th st., West New York (9)
Peckman, Abram, 2511 Boulevard, Jersey City (9)
Pecora, Carmine L., 212 Wash'gton st.,TomsRiv.(15)
Pecora, Samuel, 599 Mt. Prospect av., Newark (7)
Pedevill, Joseph R., 232 Highland av., Palisades P.(2)
Pedicini, Joseph L., 588 S. Tenth st., Newark (7)
Pedrick, William W., 11 West st., Glassboro (8)
Peer, Lyndon A., 15 Washington st., Newark (7)
Pegau, Paul M., 31 Newton av., Woodbury (8)
Pellecchia, Leonard J., 109 Parker st., Newark (7)
Pellegrini, Vincent J., 8 Summit av., Hackensack(2)
Pellet, Thomas L., Hamburg (19)
Pellicane, Anthony J.,183 Liv'gst'n av.,N.Br'sw'k(12)
Penchansky, Samuel, 719 Avenue C, Bayonne (9)
Penchansky, Samuel J., 847 Avenue C, Bayonne (9)
Pendexter, Sidney E., 11 S. Arlington av., E. Or.(7)
Pendexter, Sidney E., Jr., 11 S.Arl'gton av., E. Or.(7)
Pennington, John, 101 S. Indiana av.,AtlanticCity(1)
Pentecost, Salvador D., 14 Clarem't av., Maplew'd(7)
Peppard, Stanley H., 51 13th av., Newark (7)
Perelman, Julius S., 94 Shanley av., Newark (7)
Perez, John F., 3403 Pacific av., Atlantic City (1)
Perham, Bertram S., 199 Lorraine av.,U.Montcl'r(7)
Perillo, Louis, 638 Amboy av., Perth Amboy (12)
Perkel, Harold, 441 Boulevard, Bayonne (9)
Perkel, Louis L., 135 Jewett av., Jersey City (9)
Perlberg, Harry J., 921 Bergen av., Jersey City (9)
Perlman, Maximilian, 188 High st., Nutley (7)
Perlmutter, Irving K., 88 Clinton av., Newark (7)
Permison, Michael, 1735 Stuyvesant av., Union (7)
Pernettl, Anthony M., 400 Park av., Paterson (16)
Perrine, Cornelius C., 668 River rd., Fair Haven (13)
Perrone, Anthony J., 456 Roseville av., Newark (7)
Perrone, Arthur F., 415 60th st., West New York(9)
Perrotta, Anthony J., 42 Harding rd., Red Bank (13)
Perry, Frank L., 39 East av., Woodstown (17)
Persico, Anthony, Columbus av., Harrington Pk. (2)
Pessel, Johannes F., 224 W. State st., Trenton (11)
Peters, Richard C., 963 Park av., Plainfield (20)
Peterson, Walter R., 312 W. State st., Trenton (11)
Petrone, Peter A., 81 Roseville av., Newark (7)
Petry, William, 109 Treacy av., Newark (7)
Pettit, Harry H., 138 Franklin av., Ridgewood (2)
Pettit, Herschel, 807 Wesley av., Ocean City (5)
Phelan, Walter F., 124 Chilton st., Elizabeth (20)
Phelps, James E., 203 Park av., Paterson (16)
Phillips, Algernon A., 212 W. Market st., Newark(7)
Phillips, Ralph S., 27 S. Giles st., Bridgeton (6)
Phillips, Walter, 109 East Palisade av., Englew'd(2)
Philo, Seymour S., 849 Hamilton av., Trenton (11)
Piampiano, John, 27 Vernon av., Hamburg (19)
Piasecki, Chester A., 585 E. 29th st., Paterson (16)
Picardi, Armand A., 256 Littleton av., Newark (7)
Pickar, Gabriel, 205 N. 2nd av., Highland Park(12)
Piegari, Felix H., 111 Mt. Pleasant av., Newark (7)
Pieper, Howard C., 120 Main st., Keyport (13)
Pierson, Carl L., 900 W. State st., Trenton (11)
Pierson, Howard W., Jr., 926 Park av., Plainf'd (20)
Pierson, Joseph R., 10 E. Broad st., Hopewell (11)
Pietri, Raoul, 501 Grand av., Asbury Park (13)
Pignataro, Frank P., 342 Broad st., Red Bank (13)
Pike, Charles E., 4 E. Haddon av., Oaklyn (4)
Pilkington, Albert, 117 S. Virginia av., Atl. City (1)
Pilloni, Louis, 91 Beach st., Bloomfield (7)
Piltz, George F., 153 69th st., Guttenberg (9)
Pinck, Bernard, 100 Passaic av., Passaic (16)
Pinckney, Frank H., 186 South st., Morristown (14)
Pindar, Irene D., 164 Selvage av., W. Englewood(2)
Pindar, William A., Jr., 59 Bradley av., Bergenf'd(2)
Pinerman, Robert B., 539 W. State st., Trenton (11)
Pink, Solomon H., 21 High st., Butler (16)
Pino, Anthony, 196 Irving av., Bridgeton (6)
Pinsky, Harry A., 209 S. Sixth st., Camden (4)
Pinto, Joseph, Navy (4)
Pinto, Joseph A., 50 N. 11th st., Newark (7)
Pisciotta, Vincent, 23 Oak st., S., Mt. Ephraim (4)
Pitman, Mason W. H., 17 Ross st., Somerville (18)
Pittman, Allen R., N. J. State Hosp., Trenton (11)
Pizzi, Francis W., 205 Park av., Orange (7)
Pizzi, Mario V., 205 Park av., Orange (7)
Pizzi, Peter J., 245 Passaic av., Passaic (16)
Platt, William, West Jersey Hospital, Camden (4)
Plavin, Nathan J., 8010 Boulevard, North Bergen (9)
Plinke, Fritz W., 663 Main av., Passaic (16)
Podell, A. Alfred, 51 E. Front st., Red Bank (13)
Podkul, Theodore, 1854 Brunswick av., Trenton (11)
Pogoloff, Samuel H., 269 N. First av., Manville (18)
Pogue, Elbert H., 168 Madison av., Elizabeth (20)
Pols, John, 67 Scotland rd., South Orange (7)
Pole, Samuel B., 200 W. Commerce st., Bridgeton(6)
Poleshuck, Rubin, 100 Hollywood av., Hillside (7)
Policastro, Nelson C., 378 Union st., Hackensack (2)
Polizzotti, Joseph L., 193 Park av., Paterson (16)
Polk, Charles C., 114 E. Seventh av., Roselle (20)
Pollack, Louis, 2052 Morris av., Union (20)
Pollack, Roy, 715 Palisade av., Cliffside Park (2)
Pollard, William E., 245 Nassau st., Princeton (11)
Poller, Frederick K., 681 Stuyvesant av., Irv'gton(7)
Pollis, Nicholas L., 642 High st., Newark (7)
Pollock, Samuel L., 365 E. Schley st., Newark (7)
Pollock, Theodore, 64 Grove st., Passaic (16)
Polow, Benjamin, 200 Clinton av., Newark (7)
Polowe, David, 555 E. 27th st., Paterson (16)

Pomerantz, Samuel, 9 Madison av., Newark (7)
Pomeranz, Raphael, 31 Lincoln Park, Newark (7)
Pons, Carlos A., 501 Grand av., Asbury Park (13)
Pontery, Herbert B., 89 Bowers st., Jersey City (9)
Potekhen, George P., 1232 Park av., Plainfield (20)
Potter, Benjamin P., 821 Bergen av., Jersey City (9)
Potter, Charles W., 184 Belvidere av., Wash'gt'n(21)
Potter, Ellen C., 301 W. State st., Trenton (11)
Potter, Raymond T., 144 Harrison st., E. Orange (7)
Pottinger, William E., 6 Altamont ct.,Morristown(14)
Powell, Matthew J. G., Main st., Bedminster (18)
Powell, Robert J., 410 N. Ohio av., Atlantic City (1)
Powers, Robert W., 205 Park st., Montclair (7)
Powis, Ethel M., 845 W. State st., Trenton (11)
Poyas, Morton L., 730 W. State st., Trenton (11)
Prager, Bert A., 511 Main st., Chatham (14)
Prall, Henry E., 755 Anderson av., Cliffside Pk. (2)
Prather, Charles G., 25 Westwood av., Westwood (2)
Prather, John W., 155 Washington av., Dumont (2)
Pratt, Arthur G., 516 Cooper st., Camden (4)
Prazak, Beatrice, 1024 E. Jersey st., Elizabeth (20)
Pregnall, James P., 501 Grand av., Asbury Park (13)
Preis, Edwin E.. 3300 Federal st., Camden (4)
Price, H. Preston, 317 Hamilton rd., Ridgewood (9)
Price, Henry S., Jr., 150 Frazer av., Collingswood(4)
Price, Kasper J., 715 Westfield av., Elizabeth (20)
Prince, Robert A., 567 Broadway, Paterson (16)
Prince, Samuel, 7702 Park av., North Bergen (9)
Principato, Roberto, 402 Walnut st., Camden (4)
Probst, Everett W., 276 Willow av., Lyndhurst (7)
Proctor, Francis E., 332 W. State st., Trenton (11)
Proctor, Jesse E., 15 N. 13th st., Newark (7)
Protzman, Thomas B., 314 Engle st., Englewood (2)
Provenzani, Dominico, 419 Locust av.,Burlington(3)
Provenzano, Samuel, 317 S. Tenth st., Newark (7)
Provisor, Benjamin, 271 Lexington av., Passaic (16)
Prunetti, Carmen, 311 Chestnut av., Trenton (11)
Puff, Robert C., 509 N. Broad st., Woodbury (8)
Puller, Hyman, 217 Chestnut st., Roselle (20)
Purcell, Ernest F., 800 Stuyvesant av., Trenton (11)
Purcell, Ernest F.,Jr.,2630 Not'gh'm W.,M'rc'rv'e(11)
Purdy, Charles H., 35 Highland av., Jersey City (9)
Pusin, Max, 88 Van Reypen st., Jersey City (9)
Putter, Eric, 180 N. Main st., Milltown (12)
Pyle, Louis A., 89 Fairview av., Jersey City (9)

ASSOCIATE MEMBERS

Parker, James W.,Jr.,179 Shrewsb'y av,Red B'k(13)
Peyser, Joseph, 100 Hollywood av., Hillside (7)
Pisciotta Frank, 11th & Raritan avs., Highl'd P.(12)
Piserchia, Gerald J., 379 Washington av.,Bellev'le(7)

Q

ACTIVE MEMBERS

Quad, Clifford W., 52 Northfield av., West Orange(7)
Quigley, Frederic J., 100 Clifton pl., Jersey City (9)
Quigley, Joseph A., 8 Ziegler Tract, Penns Grove(17)
Quinn, Edward D., 323 Belleville av., Bloomfield (7)
Quinn, John J., 921 Bergen av., Jersey City (9)
Quinn, Norman J., 3303 Pacific av., Atlantic City (1)
Quirk, Martin A., 69 W. Front st., Red Bank (13)

R

ACTIVE MEMBERS

Raab, Michael, 250 Lexington av., Passaic (16)
Raban, Reginald J., 1185 Yorkship sq., Camden (4)
Rabinowitz, Jacob H., 35 Randolph pl., Newark (7)
Raccuia, Vincent, 431 59th st., West New York (9)
Rachal, Hurve J., 15 Wallace st., Newark (7)
Rachlin, Harry T., 396 Union av., Irvington (7)
Rachunis, Michael, 5th & Riverside avs.,Roebling(11)
Racz, George, 118 New st., New Brunswick (12)
Rader-Hoheb, Katherine A.,5 Linc'n av.,Ruth'rf'd(2)
Raffetto, Joseph F., 601 Bangs av., Asbury Pk.(13)
Ragany, Joseph, V.A. Hosp., Wilmington, Del. (11)
Rainey, Willard G., 34 Bayard lane, Princeton (11)
Rainone, Salvatore, 68 Park av., Maplewood (7)
Ram, Nathan H., 38 Park av., Caldwell (7)
Rampona, Joseph M., 272 Nassau st., Princeton(11)
Rampond, James R., 579 Springdale av., E. Or. (7)
Ramsey, F. Muriel, 310 E. Pine st., Millville (6)
Randazzo, Anton P., 82 Prospect st., Passaic (16)
Rapalski Adam J., Army (7)
Rapp, Robert F., 994 Haddon av., Collingswood (4)
Rappaport, Doris I., 1363 Sussex rd., W. Englew'd(2)
Rasin, Carl, 158 Lexington av., Passaic (16)
Raso, Frank L., 1218 Central av., Union City (9)
Rath, Morris, 140 Fourth av., East Orange (7)
Rathauser, Frank, 375 W. State st., Trenton (11)
Rathgeber, Charles F., 18 William st., E. Orange(7)
Rathmell, Thomas K., Mercer Hospital, Trenton(11)
Rattenne, Edward, 549 Mt. Prospect av., Newark(7)
Rauschenbach, Paul E., Jr., 612 E.29th st.,Pat's'n(16)
Ravits, Everett C., 5 Pangborn pl., Hackensack (2)
Ravitz, Samuel F., Army (7)
Rawitz, Sidney B., 42 Chancellor av., Newark (7)
Re, Natale M., 1003 Dearborn rd., Palisade (2)
Read, Hilton S., 5407 Atlantic av., Ventnor (1)
Read, Jessie D., 519 Lenox av., Westfield (20)
Read, William T., Jr., Cooper Hospital, Camden (4)
Reading, H. Eugene, 535 E. 29th st., Paterson (16)
Reale, Frank P., 427 W. Seventh st., Plainfield (20)
Reale, Nicholas P., Box 745, Manville (18)
Reason, John J., 612 Roosevelt av., Carteret (12)
Records, Carl J., Franklin & Sewell avs.,Cape May(5)
Reeve-Allen, Jane, 42 Gordonhurst av., U. M'tcl'r(7)
Reeves, Ernest, 195 Lexington av., Passaic (16)
Reich, Abraham L., 31 Lincoln Park, Newark (7)
Reich, Henry, 89 Lincoln Park, Newark (7)
Reich, Jerome J., 1500 N. Broad st., Hillside (20)
Reich, Mortimer, 705 Elizabeth av., Newark (7)
Reich, Samuel B., 286 Union st., Hackensack (2)
Reid, Erwin W., 125 Marsellus pl., Garfield (2)
Reilly, Christopher J., 331 13th av., Newark (7)

Reilly, David F., 44 Prince st., Elizabeth (20)
Reilly, John, Jr., 222 Elizabeth av., Elizabeth (20)
Reilly, John T., 18 DeHart st., Morristown (14)
Reilly, Joseph, 600 Newton av., Oaklyn (4)
Reilly, Raymond, 8210 Fourth av., North Bergen (9)
Reilly, Thomas F., 127 Union av., Clifton (16)
Reinartz, Paul V., 763 Broad st., Newark (7)
Reinfeld, Abraham G., 354 Clinton av., Newark (7)
Reinhard, Louis, 2627 Pacific av., Atlantic City (1)
Reinhardt, Warren I., 276 Springdale av., E. Or. (7)
Reinhart, Harry A., 80 S. Myrtle st., Vineland (6)
Reinhold, H. E., 441 W.Englewood av.,W.Engl'w'd(2)
Reinhorn, Abraham J., 597 E. 27th st., Paterson (16)
Reinkraut, Arthur D., 175 Broadway, Passaic (16)
Reisinger, Paul B., 369 W. State st., Trenton (11)
Reissman, Erwin, 31 Lincoln Park, Newark (7)
Reitman, Norman, 155 Livingston av.,N.Br'sw'k(12)
Reitnauer, John S., 6 Standish ct., Tenafly (2)
Relyea, George M., 129 Summit av., Summit (20)
Remondelli, Raphael E., 216 Littleton av., New'k(7)
Renna, Francis, 20 Morris av., Morristown (14)
Renner, Clara C., Blawenburg (18)
Rentrop, Chas. A.,Jr.,364 E.Ridgew'd av.,Ridgew'd(2)
Renzulli, Francesco, 228 S. Seventh st., Newark (7)
Repici, Anthony J., 212 Haddon av., Haddonfield(4)
Repta, Stephen, 2165 Morris av., Union (20)
Resch, Henry U., 185 Liberty st., Bloomfield (7)
Resnick, Nathan, 205 Market st., Trenton (11)
Resnick, Solomon, 932 Avenue C, Bayonne (9)
Ressetar, Michael, 455 Lexington av., Clifton (16)
Restaino, Charles F., 465 Parker st., Newark (7)
Restivo, Carl C., Jr., 3 Webster av., Jersey City (9)
Rettig, Isidor L., 36 Milford av., Newark (7)
Reyner, Daniel C., 2703 Pacific av., Atlantic City (1)
Reynolds, Donald G., 64 W. Main st., Freehold (13)
Reynolds, George G., 64 W. Main st., Freehold (13)
Reznikoff, Leon, 10 Columbia ter., Weehawken (9)
Rhoads, S. Creadick, 104 Station av., Westville (8)
Rhodes, Harry, Jr., 171 Terrace av., Hasbr'ckHts.(2)
Rhone, David S., 1202 Haddon av., Camden (4)
Ribbans, Robert C., 63 Central av., Newark (7)
Riccobono, Cosmo S., 334 Park av., Paterson (16)
Rice, Franklin W., 184 South st., Morristown (14)
Rich, Charles, 191 Littleton av., Newark (7)
Rich, Robert E., 191 Littleton av., Newark (7)
Rich, Wallace E., Essex Co. Hosp., Cedar Grove(7)
Richards, Ernest W., 374 DeWolf pl., Hackensack(2)
Richardson, Charles A., Closter Dock rd., Closter(2)
Richardson, Jefferson N.,101 S. Indiana av.,Atl.C.(1)
Richardson, Marvin T., P. O. Box 244, Livingston(7)
Richlan, Alfred, 181 Roseville av., Newark (7)
Richlin, Padie, 118 Johnson av., Newark (7)
Ricketts, Henry E., 25 Shepard av., Newark (7)
Rieck, Allan, 507 S. Shore rd., Pleasantville (1)
Riegert, Louis C., 808 Kings Hwy., Hadd'n Hts. (4)
Rieman, Francis E., 3564 Boulevard, Jersey City (9)
Riffin, Irving M., 419 Park st., Up. Montclair (7)
Rifici, Anthony L., 1010 Grand av., Asbury Park(13)
Riggs, Vincent J., 295 N. Arl'gt'n av., E. Or. (7)
Rineberg, Irving E., 137 Liv'gst'n av., N.Br'sw'k(12)
Ringe, Charles L., Jr., Blair pl., Blairstown (21)
Rinzler, Elliot, 211 Roseville av., Newark (7)
Rinzler, Harry G., 127 Van Houten av., Passaic(16)
Rinzler, Harvey, 614 Main st., Toms River (15)
Riordan, John P., 40 Midland av., Arlington (9)
Rise, Wilson S., 1616 Pacific av., Atlantic City (1)
Ristine, Edwin R., 300 Broadway, Camden (4)
Rita, James J., 235 S. Clinton av., Trenton (11)
Ritota, Michael C., 85 Stuyvesant av., Newark (7)
Ritter, Morton D., 1616 Pacific av., Atlantic City (1)
Rizzo, Ettore G., 352 Van Houten st., Paterson (16)
Rizzolo, Edward M., 523 Union av., Belleville (7)
Robbin, Lewis, 18 Clinton pl., Newark (7)
Robbins, Charles M., 31 Lincoln Park, Newark (7)
Robbins, Eugene, 108 Glen av., Maplewood (7)
Roberts, Allison H., 26 S. Ninth st., Newark (7)
Roberts, Charles D., 188 Sherwood pl., Englew'd (2)
Roberts, Charles, 109 S. Munn av., East Orange (7)
Roberts, David C., 3 Glen Oaks av., Summit (7)
Roberts, Dudley A., 124 St. Paul st., Westfield (20)
Roberts, Joseph E., Jr., 403 Cooper st., Camden (4)
Roberts, Richard H., 53 Kings Hwy.,W.,Had'nf'd(4)
Roberts, William A., 11 Park av., Caldwell (7)
Robertson, Eugene V., 17 Arl'gton av.,H'wth'ne(16)
Robertson, Euston S., 500 Belgrove dr., Arlington (7)
Robertson, Grace M., 515 W. Seventh st., Pl'nf'd(20)
Robie, Theodore R., 144 Harrison st., E. Orange (7)
Robinson, Aaron J., 1757 S. Broad st., Trenton (11)
Robinson, Ernest A., 149 Atkins av., Asbury P. (13)
Robinson, Louis H., 31 Lincoln Park, Newark (7)
Robinson, William A., 62 Main av., Ocean Grove(13)
Rocco, Frank, 729 Summer av., Newark (7)
Rocco, Leo C., 75 Maple av., Red Bank (13)
Rodi, Louis M., 412 Bellevue av., Hammonton (1)
Rodman, E. Warren, 503 Cooper st., Beverly (3)
Roemer, Jacob, 591 E. 27th st., Paterson (16)
Rogers, Dorothy M., 50 Cooper st., Woodbury (8)
Rogers, Herman C., Bonnie Burn San.,Scotch Pl.(20)
Rogers, James A., 274 Carroll st., Paterson (16)
Rogers, Laurence H., Donnelly M. Hosp.,Tr'nt'n(11)
Romano, Anthony M., 159 Westervelt av.,Tenafly(2)
Romano, Frank, 207 Front st., Dunellen (12)
Romano, Michael J., 2 Arlington pl., Radburn (16)
Romano, Patrick J., 310 Central av., Orange (7)
Rommer, J. Jay, 25 Ingraham pl., Newark (7)
Rona, Maurice, 10 Kirkpatrick st., N. Br'nsw'k (12)
Rooks, Wendell H., Wyckoff (2)
Roop, William O., 522 S. Shore rd., Absecon (1)
Rose, Francis L., 511 Cooper st., Camden (4)
Rose, Salvatore J., 242 Ivy ct., Orange (7)
Rose, William G., 232 Stockton st., Hightstown (11)
Roseman, Herman I., 581 Ridgewood av., Glen R. (7)
Rosen, Charles D., 115 S. Munn av., E. Orange (7)
Rosen, Charles E., 321 23rd st., Union City (9)
Rosen, Emanuel, 692 High st., Newark (7)
Rosen, Frank L., 32 Johnson av., Newark (7)
Rosen, Herbert J., 42 Hudson st., Dover (14)
Rosen, Sol, 214 N. Second st., Millville (6)
Rosenbauer, Howard J., 120 Clinton pl.,Hack'ns'k(2)
Rosenbaum, Samuel X., 261 Main st., W. Orange(7)
Rosenberg, Albert B., 120 Crescent av., Plainf'd (9)
Rosenberg, Alvin A., 22 High st., Morristown (14)
Rosenberg, Hyman, 318 Cooper st., Camden (4)
Rosenberg, Jacob, 692 Bergen av., Jersey City (9)
Rosenberg, L. Charles, 11 Murray st., Newark (7)
Rosenberg, Lillian M., 334 Bloomfi'd av.,Montcl'r (7)
Rosenberg, Louis, 1616 Pacific av., Atlantic City(1)
Rosenberg, Marvin, 174 Gregory av., Passaic (16)
Rosenberg, Norman, 10 Lincoln av., Highland P.(12)
Rosenblatt, Max B., 150 Westfield av., Elizabeth(20)
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City(1)
Rosenstein, Jacob L., 568 Bergen av., Jersey City(9)
Rosenstein, Saivel L., 2120 Springf'd av.,Vauxh'l(20)
Rosenthal, Abraham, 43 Third av., Atl. Highl'ds(13)
Rosenthal, Alfred E., 79 W. 32nd st., Bayonne (9)
Rosenthal, Arnold J., 41 Renner av., Newark (7)
Rosenthal, Oscar J., 54 Van Ness pl., Newark (7)
Rosenthal, Sydney, 202 Clinton av., Newark (7)
Rosiello, Louis E., 712 Wood st., Vineland (6)
Rosner, Edwin, 814 Haddon av., Collingswood (4)
Rosner, Francis, 653 Maywood av., Maywood (2)
Ross, Bernard, 30 E. Passaic st., Maywood (2)
Ross, Ira S., 190 Clinton av., Newark (7)
Ross, Peter W., 655 Main av., Passaic (16)
Rossi, Bartolomeo, 31 W. Main st., Bound Br'k (18)
Rossi, Gene, 148 W. Franklin st., Bound Brook (18)
Rossi, John R., 119 W. 36th st., Bayonne (9)
Rosso, John D., 194 Nassau st., Princeton (11)
Rost, Adolf S., 461 Mountainview av., Orange (7)
Roston, Mark A., 63 Hansbury av., Newark (7)

Roth, Daniel B., 836 Garrison av., Teaneck (2)
Roth, Ferdinand L., 98 S. Munn av., East Orange(7)
Rothberg, Moses, 438 59th st., West New York (9)
Rothenberg, Friedrich, 395 Ellison st., Paterson (16)
Rother, Carl, 20 48th st., Weehawken (9)
Rothfuss, C. Howard, 574 Rahway av.,W'dbr'ge(12)
Rothgesser, Jerome C., 14 Leslie st., Newark (7)
Rothhouse, Burnet, 31 Lincoln Park, Newark (7)
Rothman, Sidney, 870 Stuyvesant av., Trenton (11)
Rothschild, Carl E., 275 Grand av., Englewood (2)
Rothschild, Daniel L., 31 Lincoln Park, Newark (7)
Rothschild, Karl, 149 Livingston av., N. Br'sw'k(12)
Rotondi, Leonard J., Army (7)
Rowan, Henry M., 224 W. State st., Trenton (11)
Rowen, Manuel J., 133 W. Jersey st., Elizabeth (20)
Rowland, John H., 159 New st., New Brunsw'k (12)
Rowohlt, George O., 150 E. Madison av., Dumont(2)
Roy, Bert W., 25 Hamburg av., Sussex (19)
Roy, Joseph N., 95 17th av., Paterson (16)
Roylance, F. Dean, Jr., St. Nicholas av., Haw'th(2)
Rozsa, Stephen, 837 S. 11th st., Newark (7)
RuBacky, Joseph F. A., 61 Passaic av., Passaic (16)
Rubba, Russell R., 21 Horton st., Hammonton (1)
Rube, Joseph A., 145 Prospect st., Ridgewood (2)
Rubens, Otto, 153 E. Blackwell st., Dover (14)
Rubenstein, Eli, 783 Avenue C, Bayonne (9)
Rubenstein, Robert, 2758 Boulevard, Jersey City (9)
Rubin, Abraham A., 240 Holmes st., Belleville (7)
Rubin, Harold, 601 Grand av., Asbury Park (13)
Rubin, Jacob S., 505 Fourth av., Asbury Park (13)
Rubin, Samuel, 401 First av., Asbury Park (13)
Rubin, Sidney, 170 Hawthorne av., Newark (7)
Rubin, William, 105 Carroll pl., New Brunswick(12)
Ruby, Victor M., 325 Atlantic av., Atlantic City (1)
Ruccia, Arthur, 107 Clifton av., Newark (7)
Rudolph, John P., 108 W. Maple av., Merchantv'e(4)
Rudomanski, Victor, 103 Duke st., Kearny (7)
Ruggieri, Pasquale, 803 Elmer st., Vineland (6)
Ruggio, Joseph, 8 Hedden ter., N. Arlington (7)
Rullman, Walter A., 58 W. Front st., Red Bank (13)
Rumage, William T., 513 Sanford av., Newark (7)
Rumsey, Wm. L., Jr., 1336 North av., Elizabeth (20)
Rundlett, Emilie V., 79 Prospect st., Jersey City(9)
Runnells, John E., Bonnie Burn San.,Sc'ch Pl'ns(20)
Runyan, William J., 106 Broad st., Bloomfield (7)
Runyon, Laurence P., 80 Somerset st.,N.Br'sw'k(12)
Ruocco, William B., 416 River st., Paterson (16)
Ruoff, Andrew C., 2414 New York av., Union City(9)
Ruoff, Andrew C., III, 24 Clevel'd av., Rivervale (16)
Rush, Martin R., 326 Broad st., Red Bank (13)
Rusin, Michael, 81 Monroe st., Garfield (2)
Russell, Marie E., 583 Haddon av., Collingswood (4)
Russillo, Philip, 155 Clerk st., Jersey City (9)
Russo, Dominic T., 51 E. Somerset st., Raritan (18)
Russomanno, Paul, 497 Mt. Prospect av., Newark(7)
Russomanno, Raymond L., 227 Clifton av.,New'k(7)
Ruttenberg, Louis, 19 Hopkins st., Woodbury (4)
Ruttenberg, Max, 303 Cooper st., Camden (4)
Ryan, Lawrence W. F., 922 Haddon av.,Coll'gsw'd(4)
Rydwin, Chester, 137 Grand st., Jersey City (9)
Ryley, Harold W., 1 Lincoln pl., E. Rutherford (2)
Ryman, Merlin T., 5 Dunbar st., Chatham (14)

ASSOCIATE MEMBERS

Ridley, James B., 162 Engle st., Englewood (2)
Robertson, Robert B., 69 Maple av., Red Bank (13)
Robinson, Douglas H., N. J. State Hosp.,Trenton(11)
Rogers, Edwin D.,2500 Pennington rd.,Penn'gt'n(11)
Rosen, Albert P., 316 Kenneth av., Fair Lawn (16)
Rosen, Samuel C., 1329 Pacific av., Atlantic City(1)
Ruppert, Ralph E., 1517 N. Ohio av.,Atlantic City(1)

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ACTIVE MEMBERS

Sabarese, Theodore C., 122 Marsellus pl., Garfl'd(16)
Sabini, Cecil F., 603 Jefferson st., Hoboken (9)
Sacco, Anthony G., 2200 New York av.,Union City(9)
Sacco, Gregory E., 191 Broad st., Red Bank (13)
Sachs, Fred, 48 Warner av., Jersey City (9)
Sachs, Wilbert, 921 Bergen av., Jersey City (9)
Sackin, Stanley, 834 W. State st., Trenton (11)
Sacks-Wilner, Arthur, 225 W. State st., Trenton(11)
Sacks-Wilner, Erwin P., 225 W.State st.,Trenton(11)
Saco, Louis S., 922 Main st., Paterson (16)
Sadoff, Joseph, 504 Westminster av., Elizabeth (20)
Saffron, Morris H., 292 Paulison av., Passaic (16)
Sager, Bernard, 176 Millburn av., Millburn (7)
Sager, Harold, 19 W. 22nd st., Bayonne (9)
Sagert, Carl M., 18 Old Wood rd., Morris Pl'ns (14)
Sagi, Ellen I., 376 Elmora av., Elizabeth (20)
Sakowski, John P., 20 W. 22nd st., Bayonne (9)
Sala, Aldo W., 172 Randolph av., Clifton (16)
Saladino, Anthony J., 427 15th st., Union City (9)
Salaky, William L., 387 Neville st., Perth Amboy(12)
Salasin, Samuel L., 511 Pacific av., Atlantic City(1)
Salerno, Louis, 973 Van Houten av., Clifton (16)
Salmeri, Edward J., 253 River rd., Red Bank (13)
Salmon, George G., Jr., 243 S. Harrison st.,E. Or. (7)
Salsberg, Ralph H., 23 Johnson av., Newark (7)
Salter, Kent, Valley View San., Paterson (16)
Saltus, Lloyd S., 16 Elm st., Morristown (14)
Salva, Edo J., 17 W. Central blvd., Palisades Pk. (2)
Salvati, Leo H., 1250 Prospect st., Westfield (20)
Salvatore, Francis P., 31 Glenwood av., Jer. City (9)
Salvatore, Joseph T., 324 Hamilton av., Trenton (11)
Salway, Benjamin, 321 S. Broad st., Trenton (11)
Salzman, Nathan, 714 Broadway, Paterson (16)
Salzmann, Bertold, 89 Gifford av., Jersey City (9)
Samson, Norman D., 543 Kearny av., Kearny (7)
Sand, Abraham B., 207 E. Union st., Burlington (3)
Sandella, Joseph F., 138 Liv'gston av.,N.Br'sw'k(12)
Sandford, Francis R., 30 Academy rd., Caldwell (7)
Sandler, Moses, 2013 Center av., Fort Lee (2)
Sandler, Samuel A., 254 Union st., Hackensack (2)
Sanfacon, Thomas A., 340 Park av., Paterson (16)
Sanford, Marcus E., 27 Ross st., Somerville (18)
Santangelo, Emil L., 313 18th av., Paterson (16)
Santangelo, Joseph A., 218 Grafton av., Newark (7)
Santangelo, Stephen, 461 Jersey av., Jersey City (9)
Santor, Daniel, 27 E. Taunton av., Berlin (4)
Santora, Philip J., 361 Roseville av., Newark (7)
Santoro, Anthony, 472 12th av., Paterson (16)
Santoro, Thomas A., 141 Sanford st., East Orange (7)
Saporito, Archibald R., 119 Ridge rd., N. Arl'gton(7)
Saracino, Frank J., 107 Grand pl., Arlington (7)
Saradarian, Albert V., 921 Bergen av., Jersey City(9)
Sarajian, Aram M., 88 W. Forest av.,W.Englew'd(2)
Sargent, Eva R., 121 Myrtle av., N. Plainfield (18)

Sarla, Michael, 55 Hudson st., Hackensack (2)
Sarno, Anthony, 130 Parker st., Newark (7)
Sarno, John, 130 Parker st., Newark (7)
Sarokhan, Joseph, 771 Madison av., Paterson (16)
Saseen, Charles A., 60 S. Delancey pl., Atl. City (1)
Saslow, Benjamin I., 102 Shanley av., Newark (7)
Saslow, Stella K., 102 Shanley av., Newark (7)
Sasso, Albert, 533 Mt. Prospect av., Newark (7)
Satulsky, Emanuel M., 737 N. Broad st.,Elizab'h(20)
Sauerbrun, Bertram J. L., 681 Newark av.,Eliz.(20)
Savage, Eric D., 120 Prospect st., South Orange (7)
Savel, Lewis E., 73 Shanley av., Newark (7)
Sawyer, Blackwell, 109 Washington st., Toms R.(15)
Sax, Max T., Army (7)
Sbarra, Francesco C. N., 189 Roseville av., New'k(7)
Scalera, John F., 28 S. Plainfield av.,S. Plainf'd(12)
Scalessa, Mario F. T., 209 Ashland rd., Summit (20)
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City(1)
Scanlan, David B., 1 S. Oxford av., Atlantic City (1)
Scasserra, Benedict B., 164 Nassau st.,Princeton(11)
Scerbo, Ernest, 33-14 Broadway, Warren Point (2)
Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
Schaaf, Royal S., 51 Ellery st., Cambr'ge, Mass. (7)
Schaberg, Frank J., 263 Anderson st., Hackens'k (2)
Schaefer, Kenneth F., 763 Broad st., Newark (7)
Schaeffer, Alan M., 229 Willow st., Delanco (3)
Schafer, Marguerite A.,298 Diam'd Br.av.,H'th'ne(16)
Schaffer, Barney, 10 Van Reyper pl., Belleville (7)
Schaffer, Nathan, 172 S. Arlington av., E. Orange(7)
Schall, Reuben E., Seventh & Elm sts., Camden (4)
Schapiro, Morris, 800 Avenue C, Bayonne (9)
Schectman, Vera, 97 Lyons av., Newark (7)
Scheer, Eli, 885 Queen Anne rd., Teaneck (2)
Scheffler, Wilhelm A. H., 511 Cooper st., Camden (4)
Schefrin, Alexander E., 235 Lexington av.,Pass'c(16)
Scheiber, Geza, 769 Kearny av., Arlington (7)
Scheip, James R., II, 343 S. Pleasant av.,Ridgew'd(16)
Schellenger, Edward A. Y., 429 Cooper st.,Camden(4)
Scheller, George A., 65 Old Short Hills rd.,Short H.(7)
Schenk, Joseph R., 1177 Park av., Plainfield (20)
Schenker, Benjamin N., 246 Fifth st., Jersey City (9)
Schenker, Israel N., 3697 Boulevard, Jersey City(9)
Schept, Samuel S., 523 37th st., Union City (9)
Scher, Maurice A., 137 Lyons av., Newark (7)
Schiffmann, Samuel, 107 Spruce st., Newark (7)
Schildkraut, Jacob M., 170 W. State st., Trenton (11)
Schiller, Rosa O., 523 Westfield av., Elizabeth (20)
Schillinger, Raphael, 858 Summit av., Westfield(20)
Schimenti, Matteo, 1883 Boulevard, Jersey City (9)
Schiro, S. Robert, 73 Main st., Lodi (2)
Schisler, Milton M., 2nd & Church sts., Florence (3)
Schleifer, Arnold, 10-04 River rd., Fair Lawn (16)
Schlein, August, 707 Park av., Hoboken (9)
Schlein, David, 812 N. Wood av., Linden (20)
Schlossbach, Theodore, 94 S. Main st., Ocean Gr.(13)
Schlossberg, Ezra, 156 Amsterdam av., Passaic (16)
Schmaier, Sica L., 607 Fifth av., Belmar (13)
Schmidt, Albert F., 521 Crescent Pwy., Sea Girt (13)
Schmidt, Clifford M., 81 Main st., Newton (19)
Schmidt, Walter W., 386 Palisade av., Cliffside P.(2)
Schmukler, Jacob, 16 Johnson av., Newark (7)
Schnee, Isadore M., 586 E. 25th st., Paterson (16)
Schneider, Charles A., 694 Clinton av., Newark (7)
Schneider, Clinton R., Cedar av., Tuckerton (15)
Schneider, Harry M., 89 Gifford av., Jersey City (9)
Schneider, Leo, 171 Ferry st., Newark (7)
Schneider, Leonard, 618 Brinley av., Bradley B. (13)
Schneider, Louis, 874 S. 13th st., Newark (7)
Schneider, Louis A., 412 61st st., West New York(9)
Schnur, Bernard, 731 W. State st., Trenton (11)
Schoenau, Carl W., 15 Highland av., Glen Ridge (7)
Schorr, Herman E., 26 Lincoln Pkwy., Bayonne (9)
Schotland, Clement E., 31 Lincoln Park, Newark (7)
Schrack, Helen F., 216 N. Fifth st., Camden (4)
Schram, William S., 19A Brookdale Gar.,Bloomf'd(7)
Schramm, Joseph A., 572 High st., Newark (7)
Schreck, Harry, 192 Roseville av., Newark (7)
Schretzmann, R. C.,1289 Trafalger st.,W.Englew'd(2)
Schubert, Roy R., 466 Park av., Paterson (16)
Schuchner, William F., 550½ Jersey av., Jer. City(9)
Schuck, Traugott J., 58 Ninth st., Hoboken (9)
Schulman, Abraham S.,4518 Boulevard,Union City(9)
Schulsinger, Samuel, 80 Clinton av., Newark (7)
Schulte, Herbert A., 701 Clinton av., Newark (7)
Schults, Anna R., 25 Abington av., Newark (7)
Schultz, Augustin M., 379 Union av., Paterson (16)
Schultz, Irving A., 31-11 Broadway, Warren Pt. (16)
Schultz, Leo P., 232 Franklin Tnp., Allendale (2)
Schumacher, Evelyn L., 32 Maple av., Morrist'n(14)
Schurman, Francis H. C., 35 Smull av., Caldwell (7)
Schwartz, Albert, 280 Hobart st., Perth Amboy (12)
Schwartz, Harold, 200 Clinton av., Newark (7)
Schwartz, Harold B.,3906 Bergenline av.,Union C.(9)
Schwartz, Henry C., Raritan av., Atco (4)
Schwartz, Jacob R., P.O. Box 305, Fair Lawn (16)
Schwartz, Leo, 301 Harrison st., Passaic (16)
Schwartz, Leon J., 88 Park av., Rutherford (2)
Schwartz, Lewis, 2695 Boulevard, Jersey City (9)
Schwartz, Mortimer L., 636 Stuyves't av.,Irv'gt'n(7)
Schwartz, Samuel H., 916 Park av., Plainfield (20)
Schwartz, William, 224 Lexington av., Passaic (16)
Schwartzberg, Fred'r'k I., 522 Broadway,Pat'rs'n(16)
Schwarz, Berthold T. D., 2787 Boulevard, Jer. City(9)
Schwarz, John, 83 Highwood ter., Weehawken (9)
Schwarz, Julianna L., 115 Prospect st., Passaic (16)
Schwarz, Leopold, 237 E. Pine av., Wildwood (5)
Schwarzkopf, George C., 2901 Pacific av.,Atl.City(1)
Scialli, Vincent A., 278 Fourth st., Jersey City (9)
Sciarrillo, Louis F., 105 Newark st., Hoboken (9)
Scielzo, Nicholas F., 369 Park av., Paterson (16)
Scillieri, John, 660 Broadway, Paterson (16)
Sciorsci, Edward F., 609 Bloomfield st., Hoboken (9)
Sciorsci, Mario, 609 Bloomfield st., Hoboken (9)
Scott, Frederick J., 1 Oak st., Franklin (19)
Scott, Frederick W., 103 Bayard st., N. Br'sw'k (12)
Scott, Harold R., 68 Central av., Orange (7)
Scott, Joseph H., 129 N. Pennsylvania av.,Atl.City(1)
Scott, Kenneth H., Jr., 734 Park av., Plainfield (20)
Scott, Leonard G., 496 E. Commerce st.,Bridgeton(6)
Scott, Norman M., 790 Broad st., Newark (7)
Scott, Samuel G., 141 Bergen av., Jersey City (9)
Scovern, Louis, 299 Main av., Passaic (16)
Scranton, Charles W., 59 Washington st., E. Or. (7)
Scullion, Arthur A., 460 Anderson av., Cliffside P.(2)
Sealey, Henry J., 79 Washington av., Dumont (2)
Seda-Morales, Ruben S., 31 East av.,Woodstown(17)
Seely, Richard H., 514 Cooper st., Camden (4)
Seely, Roy B., 104 N. Clinton av., Trenton (11)
Segard, Christian P., 204 Glenwood av., Leonia (2)
Seiberling, Joseph D., 225 Redman av., Had'nfl'd (4)
Seidel, Reginald F., 164 Maple st., Englewood (2)
Seidler, Victor B., 16 Plymouth st., Montclair (7)
Seidman, Edwin A., 580 High st., Newark (7)
Seidman, Joshua I., Army (7)
Seidmon, Edward E., 221 W. Seventh st.,Plainfl'd(20)
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge(7)
Seiler, Benjamin, 580 Palisade av., Cliffside Park(2)
Seitzick-Robbins, H. E., 723 W. State st.,Trent'n(11)
Sekerak, Albert J., 984 S. Broad st., Trenton (11)
Selecky, Medard A., 35 S. Main st., Allentown (11)
Selikoff, Irving, 707 Broadway, Paterson (16)
Sellitto, Anthony M., 115 Connett pl., S. Orange (7)
Sena, Dominic R., University Hosp.,CoralG.,Fla.(20)
Sena, Marie A., 561 South Orange av., Newark (7)
Sender, Fannie, 193 Main st., South River (12)
Senerchia, Fred F., Jr., 457 Union av., Elizabeth(20)
Seto, Stanford P. T., P. O. Box 138, Blackwood (4)
Sevringhaus, Elmer L., Rensselaer rd.,Ess'x Fells(7)
Sewall, Arthur D., 52 N. Pearl st., Bridgeton (6)
Seward, Frederic H., 40 Green Vil'ge rd.,Madis'n(14)

Seward, William H., 188 S. Essex av., Orange (7)
Sewell, Stephen, 320 Passaic av., Spring Lake (13)
Sexton, Edward V., 936 Queen Anne rd., Teaneck (2)
Seybold, Arthur D., 1080 Rahway rd., Plainfield (20)
Seymour, Edward T., 55 Hillside av., Tenafly (2)
Seymour, George A., 253 Orchard st., Elizabeth (20)
Shaen, Edward, 701 N. Sixth st., Camden (4)
Shafer, Albert H., 405 Cooper st., Camden (4)
Shafer, F. William, 634 Penn st., Camden (4)
Shaffrey, Thomas A., 658 Grove st., Irvington (7)
Shaner, Ralph D., 94 Hillside av., Nutley (7)
Shangle, Milton A., 34 Prince st., Elizabeth (20)
Shangold, Jack E., 280 Hobart st., P. Amboy (12)
Shanik, Morton J., 55 W. Blackwell st., Dover (14)
Shanik, William, 601 Grand av., Asbury Park (13)
Shannon, James B., 66 S. Fullerton av., Montclair (7)
Shannon, Lardner M., 66 S. Fullerton av.,Montcl'r(7)
Shapiro, Albert B., 103 N. East av., Vineland (6)
Shapiro, Irving, 31 Lincoln Park, Newark (7)
Shapiro, Joseph S., 314 Fair st., Paterson (16)
Shapiro, Louis, 146 Broad st., Newark (7)
Shapiro, Louis G., 375 Broadway, Paterson (16)
Shapiro, Max, 414 Elizabeth av., Elizabeth (20)
Shapiro, Ralph N., 668 Clinton av., Newark (7)
Shapiro, Samuel A., 209 Avon av., Newark (7)
Shapiro, Saul J., 50 E. Lincoln av., Atl. Highl'ds(13)
Shapiro, Sydney H., 334 Union av., Irvington (7)
Sharbaugh, George B., 212 W. State st., Trenton (11)
Sharlin, Herbert S., 301 Union st., Hackensack (2)
Sharp, Charles E., Main st., Port Norris (6)
Sharp, Reuben L., 719 Cooper st., Camden (4)
Shaul, Frederick G., 10 Washington st., Bloomf'd(7)
Shaul, John F., Navy (7)
Shavelson, Irving C., 1616 Pacific av., Atl. City (1)
Shaw, Ernest B., 811 Collings av., W. Collingsw'd(4)
Shaw, John J., 31 Lincoln Park, Newark (7)
Shaw, Ned, 514 Cooper st., Camden (4)
Shayevitz, Abraham S., 102 Main st.,South River(12)
Sheaffer, Clinton P., 241 Kings Hwy.,E.,Had'nf'd(4)
Shear, M. Murray, 1158 E. State st., Trenton (11)
Shechtman, Abraham, 37 Grove st., Passaic (16)
Sheedy, John J., 121 E. Seventh st., Plainfield (20)
Sheehan, Daniel C., 535 Sanford av., Newark (7)
Sheeran, Vincent J., 101 Bentley av., Jersey City (9)
Sheets, Cecil C., 213 W. Broad st., Paulsboro (8)
Sheffield, Doreen R. C., R. D. 1, Oxford (21)
Sheft, Matthew J., 112 Lexington av., Passaic (16)
Shemeley, William G., Jr., 7 Haddon av., Camden(4)
Shenfeld, Isaac, 4806 Atlantic av., Ventnor (1)
Shepard, Adele C., 818 Summer st., Elizabeth (20)
Shepard, Morse A., 17 N. 18th st., Kenilworth (20)
Shepp, Murray, 192 W. State st., Trenton (11)
Sheppard, Alfred G., 309 Broad st., Elmer (6)
Sheppard, Muse A., Broad & Penn sts., Elmer (6)
Sheppard, Thomas S., 21 E. Vine st., Millville (6)
Sherk, A. Lincoln, 2647 Westfield av., Camden (4)
Sherman, A. Russell, 671 Broad st., Newark (7)
Sherman, Abraham, 68 Clifton ter., Weehawken (9)
Sherman, Arthur E., 70 Woodland rd., Maplewood (7)
Sherman, Elbert S., 671 Broad st., Newark (7)
Sherman, Fuller G., 204 Delaware st., Woodbury (8)
Sherman, W. Edgar, 7 Livingston av., N.Br'sw'k(12)
Shevitz, David M., 212 Grand av., Hackettstown (21)
Shier, Julius M., 585 Main av., Passaic (16)
Shill, Benjamin, 31 Lincoln Park, Newark (7)
Shinefeld, Maurice A., 675 Broadway, Paterson (16)
Shipman, James S., 514 Cooper st., Camden (4)
Shipman, Meyer P., 575 Broadway, Paterson (16)
Shipman, Robert T., 907 Summit av., Jersey City (9)
Shipps, Hammell P., 719 Cooper st., Camden (4)
Shivers, Charles H. deT., 121 S. Illinois av.,Atl.C.(1)
Shlionsky, Herman, 47 S. Park st., Montclair (7)
Shope, Edward P., 150 N. Broadway, Camden (4)
Shor, David M., 32 S. Munn av., East Orange (7)
Shreehan, Hubert F., 615 Summer av., Newark (7)
Shull, Elliott C., 517 Cooper st., Camden (4)
Shull, John V., 184 Kearny av., Perth Amboy (12)
Shulman, Abraham, 528 E. 29th st., Paterson (16)
Shulman, Murray W., 913 S. 20th st., Newark (7)
Shulman, Philip, 308 Chestnut st., Roselle (20)
Shuster, Samuel A., 405 Pacific av., Atlantic City (1)
Sica, L. Samuel, 431 E. State st., Trenton (11)
Siciliano, Thomas, 6 Clinton av., Clifton (16)
Sickel, Emanuel M., 318 Forest av., Lakewood (15)
Sieber, Isaac G., 204 Merchant st., Audubon (4)
Siegel, Jack G., 32 Johnson av., Newark (7)
Siegel, Jacob W., 96 S. Tenth st., Newark (7)
Siegel, Leo, 234 Roseville av., Newark (7)
Siegel, Lester, 180 Belmont av., Jersey City (9)
Siegel, Ralph E., 111 Market st., Perth Amboy (12)
Siegel, Robert, 96 S. Tenth st., Newark (7)
Siegel, Sidney L., 227 N. Second st., Millville (6)
Siegel, Simeon, 167 Washington av., Dumont (2)
Siegel, Victor, 43 E. Front st., Red Bank (13)
Siemion, Theophilis R., 1005 Br'sw'k av.,Trent'n(11)
Silber, Irving M., 94 Schureman st., N. Br'nsw'k(12)
Silberner, Herbert B., 99 Hillside av., Newark (7)
Silberstein, Freder'k H.,4711Westf'd av.,Merch'tv'e(4)
Silich, Robert L., 875 Boulevard, E., Weehawken (9)
Silk, Charles I., 236 High st., Perth Amboy (12)
Silon, Milton R., 907 Washington st., Hoboken (9)
Silver, Albert M., 89 Lincoln Park, Newark (7)
Silver, Michael W., 718 E. 25th st., Paterson (16)
Silvera, Salomon, N. J. Trust Bldg., Jersey City (9)
Silverman, Irving A., 164 Randolph av., Clifton (16)
Silverman, R. Louis, 21 W. Main st., Penns Gr. (17)
Silverman, S. Andrew, 860 S. 11th st., Newark (7)
Silverman, Theodore M., 105 Elmora av.,Elizab'h(20)
Silverstein, Benj. J., 32 Hillside av., Newark (7)
Silverstein, Jacob M., 73 Main st., Millburn (7)
Silverstein, Max, 605 First av., Asbury Park (13)
Simeone, Peter A., 138 Clerk st., Jersey City (9)
Simkin, Abraham, 232 Broadway, Passaic (16)
Simmons, Albert V., 720 Prospect st., Maplewood (7)
Simms, George F., 541 Page av., Lyndhurst (7)
Simon, Franklin, 89 Lincoln Park, Newark (7)
Simon, Henry, 5 Vermont av., Newark (7)
Simon, Ludwig L., 29 Hillside av., Newark (7)
Simon, Philip H., 174 Columbia av., Passaic (16)
Simonds, William R., 245 E. Front st., Plainfield(20)
Simpson, David B., 9 East 35th st., Bayonne (9)
Sims, Richard V., Jr., 31 Morris av., Summit (20)
Sinderbrand, Robert E., 344 Phila. av.,E. Harb'r (1)
Sinexon, Henry L., 36 W. Broad st., Paulsboro (8)
Singer, Bella, 640 Wyoming av., Elizabeth (20)
Singer, Max, 147 Johnson av., Newark (7)
Singer, Sina S., 3443 Boulevard, Jersey City (9)
Siniscalco, Salvatore, 801 S. Fourth st., Camden (4)
Sinkinson, Charles D.,Jr.,1616 Pacific av., Atl. City(1)
Sinnott, Gerald W., Medical Center, Jersey City (9)
Sirotta, E. Bernard, 220 W. Broad st., Paulsboro (8)
Siss, Alfred A.,198 Haledon av., Prospect Park (16)
Sisson, Nelson W., 144 Harrison st., East Orange(7)
Sivolella, Nicholas W., 245 Clifton av., Newark (7)
Siwek, Stanley, 428 Central av., Harrison (7)
Sklar, S. Harvey, 647 Anderson av., Cliffside Pk.(2)
Skvarla, John A., 17 Koster st., Wallington (2)
Skwirsky, Joseph, 37 Randolph pl., Newark (7)
Skyer, Joseph, 3400 Federal st., Camden (4)
Skyer, Roslyn P., 3400 Federal st., Camden (4)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slavin, Paul, 31 Lincoln Park, Newark (7)
Sloan, Samuel L., 182 Belmont av., Paterson (16)
Sloane, Milton B., 128 W. Hudson av., Englew'd (2)
Slobodien, Benjamin F., 233 High st., P. Amboy (12)
Slocum, Harry B., 464 Church st., Long Branch (13)
Sly, John L., 382 Springfield av., Summit (20)
Small, Louis, 101 Prospect st., Passaic (16)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, Elmer W., 69 Woodland av., E. Or. (7)

Smarzo, Marjorie M., Univ. of Ill., Champaign,Ill.(7)
Smith, Alan L., 32 Washington st., East Orange (7)
Smith, B. Earl, 1017 Greenwood av., Trenton (11)
Smith, Bertram H., 1000 Kings Hwy., Had'n Hts.(4)
Smith, Bryan A., 10 N. Monroe st., Ridgewood (2)
Smith, Charles H., 264 Ridgewood av.,Glen Ridge(7)
Smith, Charles H.,51 Livingston av.,N.Brunsw'k(12)
Smith, Christopher A., 43 Glen Ridge Pkw.,G.R'ge(7)
Smith, DeWitt H., 245 Nassau st., Princeton (11)
Smith, Ellis L., Essex Co. Iso. Hosp., Belleville (7)
Smith, Elroy W., 309 E. DeLido dr.,Miami B.,Fla.(16)
Smith, Frank W., 1238 S. Clinton av., Trenton (11)
Smith, Harold W., 179 Lincoln av., Orange (7)
Smith, Henry G., Essex Co. Hosp., Cedar Grove (7)
Smith, Herman, 306 Bates st., Phillipsburg (21)
Smith, Ivan B., Georges rd., Dayton (12)
Smith, J. James, 818 N. Broad st., Elizabeth (20)
Smith, J. Meredith, 198 Valley rd., Montclair (7)
Smith, John A., 106 Main st., South River (12)
Smith, John V., 463 State st., Perth Amboy (12)
Smith, Joseph A., N. J. Sanatorium,Glen Gardn'r(10)
Smith, Leon A., 655 Main av., Passaic (16)
Smith, Leonard H., 32 Washington st., E. Orange(7)
Smith, Marcia V., 821 Wesley av., Ocean City (5)
Smith, Marshall, 62 Bayard st., N. Brunswick (12)
Smith, Meyer, 14 Webster av., Jersey City (9)
Smith, Nehemiah E., 29 Bennett rd., Englewood (2)
Smith, Sydney F., 402 Raritan av., Highland Pk.(12)
Smith, Thayer A., Forest dr., Short Hills (7)
Smolev, Joseph M., 585 Main av., Passaic (16)
Snagg, William T., 719 Cooper st., Camden (4)
Snape, William J., 573 Stevens st., Camden (4)
Snedecor, Spencer T., 210 Main st., Hackensack (2)
Snegireff, Leonid S., 540 Parkway av., Trenton (11)
Snell, Philip, 217 Paulison av., Passaic (16)
Snyder, Howard P., 610 Salem av., Elizabeth (20)
Sobel, I. Jerome, 136 Broadway, Passaic (16)
Sobin, Julius, 190 Clinton av., Newark (7)
Sobol, Herman, 205 Roseville av., Newark (7)
Sochacki, Alexander, 1478 Mt.Ephraim av.,C'md'n(4)
Sofman, Archie, 27 Nye av., Newark (7)
Sokoloff, Oscar J., 69 Paterson st., N. Brunswick(12)
Solk, Arthur G., 47 Lincoln Park, Newark (7)
Sollami, William R., 2331 S. Broad st., Trenton (11)
Solomon, Harold, 79 Shanley av., Newark (7)
Solomon, Louis, 7 Tonnele av., Jersey City (9)
Solworth, Lee, 309 Engle st., Englewood (2)
Somberg, Harold, 31 Lincoln Park, Newark (7)
Somers, Fred L., 144 Harrison st., East Orange (7)
Somers, Willard H., 157 Engle st., Englewood (2)
Sommer, George N. J., 120 W. State st., Trenton (11)
Sommer, George N. J.,Jr.,120 W.State st.,Trent'n(11)
Sordill, Anthony, 1114 Grandview av., Westfield (20)
Soschin, Samuel J., 31 Lincoln Park, Newark (7)
Sosnow, Louis M., 51 Central av., Hillsdale (2)
Spaldo, John L., 32 Grove st., Somerville (18)
Spallone, Joseph C., 123 Mt. Prospect av., Newark(7)
Spano, Frank, 320 47th st., Union City (9)
Sparks, Paul R., 102 W. Broad st., Burlington (3)
Sparks, Spurgeon, Jr., 21 Oakwood av., Orange (7)
Spath, William H., 722 Hudson st., Hoboken (9)
Speer, Charles A., 19 Holly st., Cranford (20)
Spence, Harold G., 26 Badeau av., Summit (20)
Spencer, Alvan, 395 W. Blackwell st., Dover (14)
Spencer, Ira T., 152 Main st., Woodbridge (12)
Spencer, James H., Newton (19)
Sperber, Thomas J., 714 Cedar lane, Teaneck (2)
Sperling, Irving L., 32 Johnson av., Newark (7)
Sperling, Walter, 29 Oxford st., Montclair (7)
Spevack, Max, 536 Market st., Gloucester (4)
Spiegelglass, Abraham B., 417 Main st., Hac'ns'k(2)
Spillane, Timothy H., 379 S. Main st., Phillipsb'g(21)
Spinner, Samuel L., 15 Third st., Elizabeth (7)
Spinosa, William J., 201 Littleton av., Newark (7)
Spirito, Michael W., 219 S. Broad st., Elizabeth (20)
Spitzhoff, Frederick M., Succasunna (14)
Spivack, David, 315 W. Jersey st., Elizabeth (20)
Spivack, Seymour E., 405 Chestnut st., Roselle (20)
Spohn, Eugene L.,16 Riverton dr.,SanFrancisco,C.(9)
Sporer, Andrew, 707 Broadway, Paterson (16)
Spradley, Jeems B., E. School lane, Yardley, Pa. (11)
Sprague, Edward W., 86 Washington st., New'k (7)
Spranz, William S., 546 Oradell av., Oradell (2)
Spritzer, Theodore D.,102 S.Wash'gt'n av.,Dun'l'n(12)
Spurgeon, Chilton E., Newton (19)
Spurgeon, Dorsett L., 19 Church st., Newton (19)
Staehle, Richard H., 366 S. Orange av., S. Orange(7)
Stage, Earl DeW., 36 Maple av., Morristown (14)
Stahl, Alfred, 160 Lincoln av., Newark (7)
Stahl, Charles, 659 Sanford av., Newark (7)
Staknevich, John H., 309 Myrtle av., Irvington (7)
Stamps, G. Ruffin, 1616 Pacific av., Atlantic City(1)
Stanley, Thomas A., 77 Beech st., East Orange (7)
Stark, Jacob, 645 Broadway, Paterson (16)
Starr, Benjamin, 70 Sherman pl., Jersey City (9)
Starr, Eli, 611 79th st., North Bergen (9)
Stassi, Anthony, 481 Passaic av., Lodi (2)
Statile, Pasquale A., 598 Pavonia av., Jersey City (9)
Statman, Arthur J., 17 Leslie st., Newark (7)
Statman, Bernhardt, 849 S. 12th st. Newark (7)
Staub, E. Milton, 505 E. Broad st., Westfield (20)
Staub, Wilfred A., 531 E. Broad st., Westfield (20)
Stearns, Thornton, 312 S. Harrison st., E. Orange (7)
Steel, William A., Beesley's Point (5)
Steele, Stephen, 10 West Gibbons st., Linden (20)
Stefansin, Frank, 1601 Boulevard, North Bergen(9)
Steffens, Charles T., 612 Park av., Plainfield (20)
Stein, Albert, 600 80th st., North Bergen (9)
Stein, Emil, 607 Park av., Elizabeth (20)
Stein, Frederick, 620 Ridge rd., Lyndhurst (2)
Stein, George H., 640 Wyoming av., Elizabeth (20)
Stein, Harold M., 227 W. Broadway, Paterson (16)
Stein, Harriet N., 620 Ridge rd., Lyndhurst (16)
Stein, Isadore, 817 N. Broad st., Elizabeth (20)
Stein, Jacob M., 68 Columbia ter., Weehawken (9)
Stein, Joseph M., 414 Cooper st., Camden (4)
Stein, Louis A., 226 W. State st., Trenton (11)
Stein, William, 177 Livingston av., N. Br'sw'k(12)
Steinberg, Werner, 35 Gesner st., Linden (20)
Steiner, Edwin, 31 Lincoln Park, Newark (7)
Steiner, Herbert, 650 Stuyvesant av., Irvington (7)
Steller, Frederick C., 220 St. Clair av., Spring L.(13)
Stephenson, Daniel H., 8th & Market sts.,Camden(4)
Stephenson, Gordon A., 145 Summit av., Summit(20)
Stern, David A., 127 Lyons av., Newark (7)
Stern, Max E., 2 Milford av., Newark (7)
Stern, Morris H., 439 Clifton av., Clifton (16)
Stern, Morton M., 24 Girard pl., Newark (7)
Stetser, Leland M., 414 Cooper st., Camden (4)
Stevens, Donald J., 1479 Compton ter., Hillside (7)
Stevens, Merton H., 58 S. Maple av., East Orange (7)
Stevenson, G. McKay, 129 Summit av., Summit (20)
Stevenson, George S., R. D. Box 556, Red Bank (13)
Stewart, Irving J., 529 Kings Hwy., Swedesboro (8)
Stewart, Robert G., 79 Midland av., Montclair (7)
Stewart, Sloan G., 43 S. North Carolina av.,Atl.C.(1)
Stewart, Walter B., 8 N. Tallahassee av., Atl. City(1)
Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
Stier, Howard W., 657 Main av., Passaic (16)
Stiles, C. Campbell, 713 Park av., East Orange (7)
Stockfisch, Robert H., 3637 Boulevard, Jersey City(9)
Stoddard, Gordon V., 96 Glenwood av., E. Orange(7)
Stokes, Anthony T., 819 First st., Secaucus (9)
Stokes, Donald E., 120 Prospect st., S. Orange (7)
Stokes, James S., 32 Main st., Little Falls (16)
Stokes, S. Emlen, 129 Chester av., Moorestown (3)
Stoll, George F., 330 Washington av., Belleville (7)
Stollman, Bernard D., 21 John st., N. Brunswick(12)
Stolow, Alan A. J., 219 W. Summit st., Somerv'e(18)
Stoltz, Raymond R., 23 Passaic av., Passaic (16)

Stone, Frank P., 234 Fairmount av., Laurel Spr.(4)
Stone, Russell B., 56 Summit av., Phillipsburg (21)
Stoner, William H., 2 Broad st., Bloomfield (7)
Storaci, Frank S., 715 Hamilton av., Trenton (11)
Storer, Alexander, Jr., 563 Haddon av., Col'gsw'd(4)
Stouter, Francis L., 661 E. 18th st., Paterson (16)
Strack, Vincent J., 1072 S. Orange av., Newark (7)
Strahan, Frank G., 473 Broadway, Long Branch(13)
Strassburger, Paul J.,Jr.,330 Wash'gt'n av.,B'lev'e(7)
Straub, Herbert H., 242 Springdale av., E. Orange(7)
Straus, Frederick W., 2708 Westfield av., Camden(4)
Straus, Max, 87 Harrison pl., Irvington (7)
Straus, Walter, 1239 Greenwood av., Trenton (11)
Strauss, Arthur, 130 Pavilion av., Long Branch (13)
Strauss, Frederick, 845 S. 12th st., Newark (7)
Strauss, Max, 190 Clinton av., Newark (7)
Strauss, William T., Jr., 8 Chester rd., U.Montcl'r(7)
Strazza, John A., 183 Broad st., Bloomfield (7)
Streen, Morris E., 908 Bergen st., Newark (7)
Strelinger, Alexander, 650 N. Broad st., Elizab'h(20)
Strom, Abraham, 410 W. Seventh st., Plainfield(20)
Strully, Leonard V., 660 Broadway, Paterson (16)
Stuart, J. Earle, 552 E. Second st., Plainfield (20)
Stuart, William C., 1 Newark st., Hoboken (9)
Sturchio, Eugenio, 178 Mt. Prospect av., Newark(7)
Sturr, Robert P., Jr., 129 Fourth av., Haddon Hts.(4)
Stybel, Joseph, 507 Park av., Plainfield (20)
Subin, Harry, 2 S. Somerset av., Ventnor (1)
Sucoff, Moses C., 158 Hamilton av., Passaic (16)
Suermann, John F., 220 Palisade av.,Weehawken(9)
Suesserman, Henry, 389 Lyons av., Newark (7)
Suffness, Gustave, 970 Park av., Elizabeth (20)
Sufrin, Emanuel, 1529 Wildwood av., Camden (4)
Sullivan, Charles J., 57 Paterson st., N.Brunsw'k(12)
Sullivan, Claude C., Jr., 201 S. Logan av.,Audubon(4)
Sullivan, James M., III, 202 Spring st., Trenton (11)
Sullivan, John A., 764 Queen Anne rd., Teaneck (2)
Sullivan, William M., Jr., 43 Passaic av., Passaic(16)
Summerill, Garnett, 330 Cooper st., Camden (4)
Summers, Alfred D., 71 Palmer sq., Princeton (11)
Summey, Thomas J., 800 Golf View rd.,Moorest'n(3)
Surgent, George W., 1074 Van Houten av.,Clifton(16)
Surran, Carl A., 1616 Pacific av., Atlantic City (1)
Susinno, Anthony M., 29 Roff av., Palisades Pk. (2)
Sussman, Harold, 103 Tenth st., Hoboken (9)
Sussman, Irvin, 241 E. Commerce st., Bridgeton (6)
Suter, Harry F., 49 W. Main st., Penns Grove (17)
Sutnick, Theodore B., 25 Richey pl., Trenton (11)
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove (7)
Svenson, Sven E.,New'k Pompton Tpk.,P'pt'n Pl.(7)
Swain, Richard D., Jr., 211 Roseville av., Newark(7)
Sweeley, William J., 17 Smull av., Caldwell (7)
Sweeney, Ralph E., 406 Elmora av., Elizabeth (20)
Swern, Nathan, 399 W. State st., Trenton (11)
Swiecicki, Martin E., 9 Second av., Hadd'n Hts.(4)
Swiney, Juliana C., 325 Avenue C, Bayonne (9)
Swiney, Merrill A., III, 325 Avenue C, Bayonne (9)
Sydoriak, Vladimir L.,51 Park Blvd.,Lanc't'r,N.Y.(6)
Symes, Earl R., 544 Belgrove dr., Kearny (7)
Szafir, Paul, Veterans Administration, Lyons (16)
Szelewa, Edward S., 87 Stuyvesant av., Newark (7)
Szivos, Louis A., 160 Glenwood av., East Orange (7)
Szold, Norman F., 701 Princeton av., Lakewood (15)
Szot, Alexander, 747 Ridge rd., Lyndhurst (2)
Szuch, Nicholas, 159 Main st., South River (12)
Szymanski, John J., 616 Main av., Passaic (16)

ASSOCIATE MEMBERS

Sabety, Adrian M., 29 Park ct., Verona (7)
Sakson, John, 117 Centre st., Trenton (11)
Samaha, Charles, 7 Sunset dr., Asbury Park (13)
Scales, Harold L., 805 Red rd., Teaneck (2)
Sciano, Edward A., 109 Broadway, East Paterson(2)
Shapiro, Myron J., 89 Lincoln Park, Newark (7)
Sheehan, George A., 27 Irving pl., Red Bank (13)
Shipper, Harvey, 949 Berkeley av., Trenton (11)
Shpetner, Aaron F., 29-A Boulevard, E.Paterson(16)
Sinnott, John, Jr., Rumson rd., Rumson (13)
Small, Leon I., 250 Millburn av., Millburn (7)
Solomon, Philip, 32 Johnson av., Newark (7)
Sorrentino, Louis V., 92 S. Oraton Parkway,E.Or.(7)
Southard, Samuel C., 112 St. Davids pl., Atl. City(1)
Spieler, Ernesta M., 493 Central av., Newark (7)
Sturman, William A., 219 S. Harrison st., E. Or.(7)
Sullivan, John E., Jr., 839 Kearny av., Arlington(7)

T

ACTIVE MEMBERS

Taber, Frederick S., 55 Paterson st., N. Br'sw'k(12)
Taber, Leslie R., 292 Broadway, Paterson (16)
Taff, Harry, 165 Roseville av., Newark (7)
Taffet, Seymour, 55 W. Passaic av., Bloomfield (7)
Taffet, William, 379 Union av., Belleville (7)
Talmage, William G., Main st., Succasunna (14)
Talty, John C., 935 Washington st., Hoboken (9)
Tannert, Carl H., 331 77th st., N. Bergen (9)
Tansey, W. Austin, Jr., 169 Hobart av.,ShortHills(7)
Taranto, Michael, 13 E. Gibbons st., Linden (20)
Tarbell, Harold A., 13 Pennington st., Newark (7)
Tarchiani, Lucius S., 472 River st., Paterson (16)
Targan, Nathan, 27 N. Connecticut av., Atl. City (1)
Tarta, Ciro S., 654 E. 18th st., Paterson (16)
Tataryan, Hovsep, 2024 New York av., Union City(9)
Tatem, Henry R., Jr., Pine st., Audubon (4)
Taterka, Adrian, 3 Gates av., Roseland (7)
Tator, Arthur E., 57 DeForest av., Summit (20)
Taylor, Halley B., Jr.,221 Hamilton av.,Paterson(16)
Taylor, Raymond A., 58 Madison av., Lakewood(15)
Teichholz, Max H., 19 Meade av., Passaic (16)
Tell, M. Edward, 249 Lexington av., Passaic (16)
Teller, Daniel W., Jr., 28 DeHart st., Morristown(14)
Tenney, Albert S., 6 N. Munn av., East Orange (7)
Tenney, Luman H., 177 Prospect av., Princeton (11)
Tennis, Edgar M., 375 Engle st., Englewood (2)
terKulle, Reinold W., 88 W.Ridgew'd av.,Ridgew'd(2)
Terrerl, D. Joseph, 30 High st., Morristown (14)
Terwedow, Walter G., 518 79th st., North Bergen (9)
Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
Tether, Russell K., Main st., Closter (2)
Thalhelmer, Edward J., 7th & Plum sts., Vineland(6)
Thetford, Norman D., 68 South st., Eatontown (13)
Thomas, Claude W., 28 East av., Woodstown (17)
Thomas, George N., 8th & Grape sts., Vineland (6)
Thomas, Irene O., 350 Lafayette av., Hawthorne (16)
Thomas, John H., 270 Lenox av., South Orange (7)
Thomas, Leon H. S., 631 E. 22nd st., Paterson (16)
Thomas, Thomas S., Jr., 18 Elm st., Morristown (14)
Thomison, Harry E., 605 Broad st., Newark (7)
Thompson, Edward C., 373 Park av., Paterson (16)
Thompson, Frank F., Jr., 261 Orange rd.,Montclair(7)

Thompson, Kenneth W., Organon, Inc., Orange (7)
Thompson, Minturn R., 530 W. Broad st.,Westf'd(20)
Thompson, P. H., 4612 Westf'd av.,Penns'k'n Tsp.(4)
Thompson, T. M., 601 S. First av., Highland Pk.(12)
Thompson, Victor, 80 W. Front st., Keyport (13)
Thompson, Walter A., 714 Ackerman av.,Glen R.(16)
Thompson-Bohne, Mildred H.,62 Elm st., Summit(20)
Thorne, William P., 254 Main st., Butler (16)
Thornhill, Arthur C., 47 Forest st., Montclair (7)
Thornley, William F., 495 Prospect st., Maplew'd (7)
Thron, Leopold E., 791 Broadway, Paterson (16)
Thum, Kurt W., 366 Main st., West Orange (7)
Thurm, Arthur S., 225 W. State st., Trenton (11)
Tidaback, Austin J., 981 Townley av., Townley (20)
Tidwell, Harold F., 6101 Boulevard, E., W. N. Y. (9)
Tilley, John A., 165 Main st., Keyport (13)
Tillis, Herman H., 31 Lincoln Park, Newark (7)
Tilton, William R., 763 Broad st., Newark (7)
Timberlake, Baxter H., 5414 Ventnor av.,Ventnor(1)
Tisch, Leon, 28 S. Third av., Highland Park (12)
Tobey, Franklin J., 11 Hazelwood av., Newark (7)
Tobey, John R., 11 Hazelwood av., Newark (7)
Tobin, Joseph M., N. J. State Hosp.,Marlboro (13)
Tocci, Frank, 74 Grove st., Montclair (7)
Toczek, Heinrich A., 391 Bergen st., Newark (7)
Tolomeo, Martin E., 5 E. High st., Bd. Brook (18)
Tolor, Stanley, 405 Westminster av., Elizabeth (20)
Tomec, Otto C., 756 Parkway av., Trenton (11)
Tomec, Richard F., 70 Harrison av., Montclair (7)
Tomkins, William, 105 Fairmount rd., Ridgew'd(16)
Tomlins, Francis I., 97 Madison pl., Ridgewood (2)
Tomlinson, Rolland D., 502 E. Broad st.,Westf'd(20)
Tompkins, Grenelle B., 52 Broad st., Flemington (10)
Topley, Howard E., Jr., 8 Oak lane, Trenton (11)
Toren, Julius A., R. D. 1, Box 95, Long Branch (13)
Torppey, John J., 472 Sanford av., Newark (7)
Toscano, George A., 364 Park st., Hackensack (2)
Townsend, John B., 824 Wesley av., Ocean City (5)
Townsend, Leslie M., 420 Chestnut st., Roselle P.(20)
Toy, Calvert R., 22 Kirkpatrick st., N. Br'sw'k (12)
Tracy, George T., 222 Warren st., Beverly (3)
Traganza, Robert W., 428 Richey av.,W.Col'gsw'd(4)
Trano, Giovanni, 941 E. Jersey st., Elizabeth (20)
Trautwein, Charles F., 131 Nesbit ter., Irvington(7)
Travers, Frank A., 485 Park av., Orange (7)
Treiber, Benjamin A., 219 W. State st., Trenton (11)
Trewhella, Arthur P., 376 Fairmount av., Jer.City(9)
Triarsi, Anthony J., 702 Third av., Elizabeth (20)
Trilling, Leonard J., 423 Broadway, Paterson (16)
Trippe, Morton F., 702 Asbury av., Asbury Park(13)
Troast, Leonard, 2801 Boulevard, Jersey City (9)
Troedsson, Bror S., 188 S. Essex av., Orange (7)
Troum, Nathan, 82 Danforth av., Jersey City (9)
Truax, Alfred J., Main st., Chester (14)
Tsucalas, James C., 29 Highland av., Jersey City(9)
Tucker, Albert B., 47 Lincoln Park, Newark (7)
Tucker, Sidney, 211 Madison av., Perth Amboy (12)
Tuly, Ralph, 134 S. Kingman rd., South Orange (7)
Tunis, Benno B., 22 Ingraham pl., Newark (7)
Turi, Amedeo E., 407 Mt. Prospect av., Newark (7)
Turkish, Martin, 1025 Avenue C, Bayonne (9)
Turner, Charles F., 151 Grove st., Montclair (7)
Turner, Rodney C., 609 Greenwood av., Trenton (11)
Tushnet, Leonard, 662 18th av., Irvington (7)
Tutela, Arthur C., 220 S. Seventh st., Newark (7)
Tweddel, George K., 239 Broadway, Paterson (16)
Tyler, Charles O., 134 Kings Hwy.,E.,Hadd'nf'd (4)
Tymeson, Walter R., 310 Main st., Orange (7)
Tyndall, Alice D., 127 Maple av., Red Bank (13)
Tyndall, Alice E., 263 Walnut st., Westfield (20)
Tyndall, Hugh H., 83 Highwood ter., Weehawken(9)
Tyndall, Martha W., 263 Walnut st., Westfield (20)
Tyson, Edward B., 391 55th st., Ocean City (5)

ASSOCIATE MEMBERS

Teaze, Allison D., 62 Claremont av., Bloomfield (7)
Thompson, John J., Mountainside Hosp., Montcl'r(7)
Tucci, Peter, 74 Chestnut st., Montclair (7)
Tweddel, George K., Jr., 505 Park av., Paterson (16)

U

ACTIVE MEMBERS

Udinsky, Hyman J., 57 Passaic av., Passaic (16)
Uhr, Jacques S., 127 Livingston av., N. Br'sw'k(12)
Ulan, Jerome, Main st., Spotswood (12)
Ulan, Oscar, 92 Fleming av., Newark (7)
Ulmer, Chester I., 431 W. Broad st., Gibbstown (8)
Ulmer, D. H. Bartine, 199 Chestnut st., Moorest'n(3)
Ulvestad, Lawrence E., 119 Irvington av., S. Or. (7)
Underwood, J. Harris, 509 N. Broad st., Woodbury(8)
Underwood, Robert, 345 Washington av., Bellev'e(7)
Upham, Helen F., 305 Third av., Asbury Park (13)
Urbach, George, 181 Chancellor av., Newark (7)
Urban, George J., Jr., 40 Egan st., Fords (12)
Urbaniak, Henry S., 883 Brunswick av., Trenton(11)
Urbanski, Matthew F., 148 Market st., P. Amboy(12)
Urevitz, Abraham, 2415 New York av., Union C. (9)
Urie, Murray G., 394 E. 30th st., Paterson (16)
Uzzell, Edward F., 2703 Pacific av., Atlantic City(1)

V

ACTIVE MEMBERS

Vaczi, Stephen, 983 S. Broad st., Trenton (11)
Valentin, Irmgard, 131 S. Harrison st., E. Orange (7)
Vallario, Frank A., 333 Clifton av., Newark (7)
Van Amberg, Robert J., 25 Trinity pl., Montclair(7)
Vandenberg, Werner, 7 S. La Clede pl., Atl. City (1)
Vanderbeck, James J., 123 Prospect st.,Ridgew'd(16)
Vanderbeek, Andrew B., 174 Broadway,Paterson(16)
Vanderbeek, Frank B., 683 E. 27th st., Paterson (16)
Vanderbeek, Stuart W., 143 Engle st., Englewood(2)
Vander Bush, Edward F.,534 E.29th st.,Paterson (16)
Vandersluis, Harold H., 40 Pascack rd., P. Ridge(2)
Vander Veer, H. Garrett, 295 M'tg'm'y st.,Bl'mf'd(7)
Van Dyke, Laura V., 125 Hamilton st., Bd. Brook(18)
Van Eerde, Albert, 339 Lafayette av., Hawth'ne(16)
Van Eerde, Albert, 911 N. Wood av., Linden (20)
Van Emburgh, George H., 575 Belgr'e dr.,Arl'gt'n(7)
Van Gieson, Edward J., 71 Watsessing av.,Bl'mf'd(7)
Van Horn, Abram L., 744 Broad st., Newark (18)
VanMater, John S., 61 Livingston av., N.Br'sw'k(12)
Van Meter, Ralph H., 224 E. Main st., Moorest'n(3)
Vann, Dorothea D., 460 Engle st., Englewood (2)
Vann, Felix H., 179 Hillside av., Englewood (2)
Vannatta, George W., 226 N. Park st., E. Orange (7)
Vanneman, Joseph S., 45 Princeton av.,Princet'n(11)
Van Ness, H. Roy, 444 Parker st., Newark (7)
Van Ness, Walter J., 41 Park pl., Bloomfield (7)
Van Riper, Wm.D.,441W.Englew'd av.,W.Eng'w'd(2)
Van Schott, Gerard J.,Jr.,245Lex'gt'n av.,Passaic(16)
Van Wiemokly, Seymour S.,201Sp'dw'l av.,M'r't'n(14)
Van Winkle, Charles I., 79 Ridge rd., Rutherford(2)
Van Winkle, John S., 297 Broadway, Paterson (16)
Vargish, Hildegard S.,268K'd'rk'm'k rd.,N.H'k'ns'k(2)
Vargish, Jacob, 268 Kinderk'm'k rd.,N.Hack'ns'k(2)
Vargyas, Joseph C., 116 New st., N. Brunsw'k (12)
Varhol, Joseph G., 436 Clifton av., Clifton (16)
Varney, William H., 122 Belvidere av.,Wash'gton(21)
Varriano, John L., 3263 Boulevard, Jersey City (9)
Vento, Sebastian J., 452 Hamilton av., Trenton (11)
Verdon, Robert E., 682 Anderson av., Cliffside (2)
Verga, Armand, 20 Main st., Manasquan (13)
Vermes, Leslie, 380 Rutherford av., Franklin (19)
Vermeulen, Abram, 344 Haledon av., Prosp't P. (16)
Vernaglia, Anthony P.,418 Lincoln av.,H'wth'ne(16)
Vespignani, Pasquale, 863 Montgom'y st.,Jer.City(9)
Villanova, Ralph N., 266 S. Eighth st., Newark (7)
Villapiano, Joseph G., 701 Sunset av., Asbury P.(13)
Vincent, Nicholas F., 144 Harrison st., E. Orange (7)
Vinciguerra, Michael, 604 Westm'ster av.,Eliz'b'h(20)
Vine, Blair, 1437 S. Broad st., Trenton (11)
Virgilio, Anthony A., 87 S. Centre st., Orange (7)
Visceglia, Frank R., 430 74th st., N. Bergen (9)
Visconti, Joseph A., 105 Newark st., Hoboken (9)
Vita, Frank J., Army (2)
Vitale, Dominic V., 749 N. Broad st., Elizabeth (20)
Viteri, Luis E., 214 Main st., Mt. Holly (3)
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth (20)
Vogel, Nathan F., 297 Morris av., Springfield (20)
Vogel, Wolfgang F., 546 E. 29th st., Paterson (16)
Volpe, Donald J., 503 Central av., Hammonton (1)
Vol-Tretter, Marta, 501 W. State st., Trenton (11)
von Deilen, Arthur W., 530 Cooper st., Camden (4)
von Deilen, Henry O., 28 DeHart st., Morristown(14)
Von Hofe, Frederick H., 572 Park av., E. Orange (7)
Von Oehsen, William H., 623 4th av., Bradley B.(13)
Voorhis, Charles F., 330 Morgan av., Palmyra (3)
Vosburgh, Fred, 663 Main av., Passaic (16)
Voss, J. Landon, 212 South st., Morristown (14)
Vostrosablin, Nicholas A., 121 Grand st.,Jer. City(9)
Vreeland, Ralph J., 278 McKinley pl., Ridgew'd (16)
Vroom, William L., 88 W. Ridgew'd av., Ridgew'd(2)

ASSOCIATE MEMBERS

Vaccaro, Henry J., 509 Fourth av., Asbury Park(13)
Vail, William D., 73 Hobart av., Short Hills (7)
Vogel, Helga S., 546 E. 29th st., Paterson (16)

W

Wacker, William F., 1224 Salem av., Hillside (20)
Wade, Francis A., 12 Mt. Kemble av., Morrist'n(14)
Wade, George R., 129 Chester av., Moorestown (3)
Wager, Henry P., 39 Gifford av., Jersey City (9)
Wagner, Richard, 915 Springfi'd av.,N.Provid'ce(20)
Wainright, Melvin A. R., 286 Broad st.,Red Bank(13)
Wakeley, William E., 144 Harrison st., E. Orange(7)
Wakeley, William E.,Jr.,47 Virginia av.,Livingst'n(7)
Waldron, Edward L., 910 Stuyvesant av.,Trenton(11)
Waldron, Robert E., 699 Kearny av., Arlington (7)
Walkenberg, Michael, 56 Clinton pl., Newark (7)
Walker, Ada H., 635 Landis av., Vineland (6)
Walker, H. Burton, 635 Landis av., Vineland (6)
Walker, Harold G., 252 Everett av., Wyckoff (16)
Walker, Levi M., 5407 Atlantic av., Ventnor (1)
Walker, Nelson C., 261 Summit av., Hackensack (2)
Walker, Otto, 198 Pershing av., Carteret (12)
Walker, Robert B., 108 Church st., N. Brunsw'k(12)
Wallace, Marc J., 165 Lakeview av., Clifton (16)
Wallach, Bernard, 74 Watchung av., N. Plainfi'd(18)
Wallack, Charles A., 23 Treacy av., Newark (7)
Wallack, Eli A., 92 Fairview av., Jersey City (9)
Wallen, Benjamin B., 217 E. Pine av., Wildwood (5)
Walsh, Charles R., 95 W. Northfield av.,Liv'gston(7)
Walsh, Ronald J., 338 S. Broad st., Elizabeth (20)
Walsh, Thomas J., 335 S. Broad st., Elizabeth (20)
Walters, George M., 158 Main st., Woodbridge (12)
Walton, Gordon G., 575 E. 28th st., Paterson (16)
Walton, Ralph W., 102 Gates av., Montclair (7)
Wannemacher, Paul, 87 Valley Way, W. Orange (7)
Warburton, Jack C., 333 Park av., Paterson (16)
Ward, Albert J., 39 Elm st., Morristown (14)
Ward, Chauncey P., 118 S. Grove st., E. Orange (7)
Ward, Elisabeth B., 555 William st., E. Orange (7)
Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
Ward, Mary, 30 Engle st., Tenafly (2)
Ward, William R., 112 Chancellor av., Newark (7)
Ward, William R., Jr., 112 Chancellor av.,Newark(7)
Ware, Carl N., Bridgeton rd., Shiloh (6)
Warnecke, Rudolph E., 43 S. Maple av.,E. Orange(7)

Warner, William H. A., 444 Central av.,E. Orange(7)
Warren, Charles B., 181 Prospect av., Bergenf'd (2)
Warren, David E., 48 Rutgers pl., Passaic (16)
Warren, Earl L., Box 1738, Paterson (16)
Warren, Jacob, 308 18th av., Paterson (16)
Warter, John P., Jr., 570 Belgrove dr., Arlington (7)
Warter, Peter J., 717 W. State st., Trenton (11)
Warwick, Ralph A., 3300 Federal st., Camden (4)
Washington, William H., 321 High st., Newark (7)
Wassing, Hans, 695 Broadway, Paterson (16)
Waterman, Samuel M., 41 Shanley av., Newark (7)
Waters, Charles H., 928 W. State st., Trenton (11)
Waters, Edward G., 39 Gifford av., Jersey City (9)
Watman, Anthony J., 2784 Boulevard,Jersey City(9)
Watov, Samuel E., 178 W. State st., Trenton (11)
Watts, Wilbur, 436 E. State st., Trenton (11)
Waugh, Bascom S., 1882 S. Tenth st., Camden (4)
Way, Clarence W., 4515 Landis av., Sea Isle City (5)
Wayman, Bernard R., 1100 S. Broad st., Trenton(11)
Webb, Eleanor A., 887 Springfield av., Summit (20)
Weber, Francis C., 286 Mt. Prospect av., Newark (7)
Weber, John F., 264 Main st., South Amboy (12)
Weber, Laura E., 305 23rd st., Union City (9)
Weeks, Belford A., 534 S. Shore rd., Absecon (1)
Weems, Don B., 105 E. Mantua av., Wenonah (8)
Wegryn, Louis S., 257 Elizabeth av., Elizabeth (20)
Weigel, Edgar W., 210 W. Jersey st., Elizabeth (20)
Weigel, Elmer P., 727 Watchung av., Plainfield (20)
Weimann, Max L., 803 Station av., Haddon Hts. (4)
Weinberg, C. Richard, 597 Clinton av., Newark (7)
Weiner, Aaron, 660 Broadway, Paterson (16)
Weiner, Harry, 283 Franklin st., Bloomfield (7)
Weiner, Henry T., 280 Hobart st., Perth Amboy(12)
Weiner, Samuel E., 904 Pacific av., Atlantic City(1)
Weinert, Henry V., 128 Market st., Passaic (16)
Weinmann, Max H., 714 Scotland rd., Orange (7)
Weinstein, Alvin, 300 Deal Lake dr., Asbury Pk.(13)
Weinstein, Francis S., 840 S. 11th st., Newark (7)
Weinstein, Morris W., 942 Sanford av., Irv'gton (7)
Weinstein, Robert A., 214 Spring st., Newton (19)
Weintraub, William L., 400 Broadway, Paterson (16)
Weintrob, Joseph R., 1616 Pacific av., Atl. City (1)
Weisbrod, Ferdinand G., 61 S. Munn av., E. Or.(7)
Weiser, Edward H., 1 East Main st., Sussex (19)
Weisman, Herbert, 273 Avenue A, Bayonne (9)
Weisman, Stephen L., 526 Broadway, Paterson (16)
Weiss, Fred, 129 Elizabeth av., Newark (7)
Weiss, Herman, 300 Madison av., Madison (14)
Weiss, Louis, 519 Springfield av., Newark (7)
Weiss, Morris J., 734 Avenue C, Bayonne (9)
Weiss, Samuel A., 786 Palisade av., Teaneck (2)
Weiss, Selma, 190 Clinton av., Newark (7)
Weiss, William I., 80 Clinton av., Newark (7)
Weissberg, Wm. W., 800 N. Broad st., Elizabeth(20)
Weissman, Meyer T., 1137 E. Jersey st., Elizab'h(20)
Weitz, Abraham, 2512 S. Chester av.,Bakersf'd,C.(20)
Welkind, Allen A., 32 Johnson av., Newark (7)
Weller, Arthur, 19 Hillyer st., Orange (7)
Weltchek, Herbert, 439 Jersey av., Elizabeth (20)
Wender, Harold, 103 Clinton st., S. Bound Brook(18)
Wentz, Iri Z., 224 Webster av., Seaside Heights (15)
Wentzell, J. Earl, 5 E. Mantua av., Wenonah (8)
Wescoat, George N. A., 202 W. Main st.,Moorest'n(3)
Wesson, Harrison R., 198 Valley rd., Montclair (7)
West, Guernsey F., Barrymore st., Phillipsburg(21)
Westerhoff, Peter D., 51 Highland av.,Midland P.(16)
Westney, F. Rolfe, 7602 Ventnor av., Ventnor (1)
Weston, Clifford G., 27 Woodland av., Glen Ridge(7)
Weston, Elaine, 40 Midland av., Arlington (9)
Wetherhold, John M., 20 Ziegler Tract, Penns G.(17)
Wetterberg, Louis F., Amboy av., Woodbridge (12)
Whaland, Berta, 117 Atlantic st., Bridgeton (6)
Wheaton, Henry H., 42 Grove st., Verona (7)
Wheeler, James A. V., 85 Van Reypen st.,Jer.City(9)
Wheeler, William K., 140 Roseville av., Newark (7)
Whelan, Edward P., 460 Franklin av., Nutley (7)
Whelan, Vincent, 67 E. Front st., Red Bank (13)
Whigham, Herbert H., Jr.,38 Madison av., M'tcl'r(7)
Whims, Clarence B., 5407 Atlantic av., Ventnor (1)
Whitaker, Darrell W.,802 Penn'gton av.,Trent'n(11)
Whitaker, Henry J., 10 S. Broadway, Pitman (8)
Whitaker, John C., 402 Lippincott av., Riverton (3)
White, Frank S., 916 Red rd., Teaneck (2)
White, Harry J., Roosevelt Hospital, Metuchen (12)
White, R. Rostin, 644 Shore rd., Somers Point (1)
White, Robert R., 144 Harriston st., East Orange(7)
Whiticar, John H., Box 235, Ocean City (5)
Whitken, Albert I., 1056 North av., Elizabeth (20)
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield(2)
Whitney, Leon H., 540 Broad st., Newark (7)
Wiant, Herman E., 120 Windsor av., Haddonf'd (4)
Wichman, Heins, 28 DeHart st., Morristown (14)
Widdowson, William W., Bell Tele. Lab.,Mur.Hill(20)
Widetsky, Alfred, 85 Broadway, East Paterson (2)
Wiener, David, 196 Weequahic av., Newark (7)
Wiesenfeld, Benjamin, 570 Barron av.,Woodbr'e(12)
Wiesenfeld, Paul, 138 Market st., Perth Amboy (12)
Wiggins, Ulysses S., 1025 S. Fourth st., Camden (4)
Wikoff, John L., 799 Pennington av., Trenton (11)
Wilbur, Franklin L., 515 Eighth av., Asbury Pk.(13)
Wilcox, Frank A., 329 60th st., West New York (9)
Wilcox, John M., III, 415 Lake av., Pitman (8)
Wildman, Edward D.,119 Chester av.,Moorestown(3)
Wilentz, William C., 188 Market st., P. Amboy (12)
Wiley, Herman O., 326 Shrewsbury av.,RedBank(13)
Wilkins, Stanley O., 47 E. Front st., Red Bank (13)
Willan, Edward H., 74 S. Munn av., East Orange (7)
Willetts, Arthur T., 129 Summit av., Summit (20)
Willey, F. Parker, 153 Roseville av., Newark (7)
Willey, Harry S., Jr., 112 Broad st., Red Bank (13)
Williams, David P., 116 Lake dr.,Mountain Lks.(14)
Williams, Edith B., 70 Anderson st., Hackensack (2)
Williams, Frank A., 324 W. Jersey st., Elizabeth(20)
Williams, Harry D., 829 W. State st., Trenton (11)
Williams, Hiram, P. O. Box 266, Montclair (16)
Williams, John T., 78 Walnut st., Newark (7)
Williams, John R., 681 Anderson av., Cliffside P. (2)
Williams, Leonard D., 726 Watchung av.,Plainf'd(20)
Williams, Manley C., 735 E. Milton av., Rahway(20)
Williams, Raymond A., 7207 Atlantic av.,Ventnor(1)
Williams, William C., 9 Ridge rd., Rutherford (2)
Williams, William C., Black Horse Pk.,Had'n Hts.(4)
Willis, Benedict P., 185 Montross av., Rutherford (2)
Willner, Albert, Army (7)
Willner, Irving, 18 Waverly av., Newark (7)
Willner, Milton, 822 S. 12th st., Newark (7)
Willner, Philip, 852 S. 11th st., Newark (7)
Willson, James H., 144 Harrison st., East Orange(7)
Wilner, Daniel, 5407 Atlantic av., Ventnor (1)
Wilson, Charles W., 636 Wood st., Vineland (6)
Wilson, Harrison B., 430 Union st., Hackensack (2)
Wilson, Herbert H., 24 Bank st., Bridgeton (6)
Wilson, John H., Jr., 85 Halsted st., East Orange(7)
Wilson, Jon M., 125 Hamilton st., Bound Brook(18)
Wilson, Joseph G., 560 Rutherford av., Trenton (11)
Wilson, Lawrence A., 114 N. Shore rd., Absecon (1)
Wilson, Lester R., 3320 Federal st., Camden (4)
Wilson, Robert B., 48 Riverside av., Red Bank (13)
Winder, Miles S.,Jr.,602 Blanch'd Pwy.,W.Al'nh't(13)
Winfield, Irwin, 493 Central av., Newark (7)
Winn, James S., 51 Livingston av., N. Brunsw'k(12)
Winn, Samuel L., 1616 Pacific av., Atlantic City (1)
Winn, William M., 128 Broad st., Perth Amboy (12)
Winslow, John, 210 Orange rd., Montclair (7)
Winslow, John H., 27 S. Valley av., Vineland (6)
Winter, Carl M., 1518 Collings rd., Camden (4)
Winter, Egon W., 825 S. Tenth st., Newark (7)
Winter, Gladys C., 790 Grange rd., Teaneck (2)
Winters, Walter M., 288 Broadway, Paterson (16)
Witkoff, Benjamin, 215 Terrace av., Hasbr'k Hts. (2)

Witman, H. John, Jr., 526 N. Clinton av.,Trenton(11)
Witmer, John D., 456 Middlesex av., Metuchen (12)
Witte, C. Norman, 422 River av., Point Pleasant(15)
Wittenborn, William F.J.,1635Br'sw'k av.,Trent'n(11)
Wolf, Erich, 43 Grove st., Passaic (16)
Wolf, Frank A., 494 S. Main st., Phillipsburg (21)
Wolf, Israel J., 231 East 31st st., Paterson (16)
Wolf, Raymond E., 251 Ridgewood av.,GlenRidge(7)
Wolfe, Edward E., 895 Queen Anne rd., Teaneck (2)
Wolfe, Humphrey D., 23 Spring st., Penns Gr. (17)
Wolfe, Jacob S., 44 Watsessing av., Bloomfield (7)
Wolfe, William W., 383 Mulberry st., Newark (7)
Wolff, Herbert M., 942 W. State st., Trenton (11)
Wolff, Jerome M., 935 Park av., Plainfield (20)
Wolfsie, Jacob H.,American Cyanamid Co.,Lind'n(18)
Wolfson, Harry, 356 Park av., Paterson (16)
Wolgin, Philip L., 445 Elmora av., Elizabeth (20)
Wollack, Alfred, 9 Park av., Park Ridge (2)
Wolowitz, Harry B., 20 Spring Val.av.,Hackens'k(2)
Wood, E. LeRoy, 225 Ballantine Pkwy.,Newark (7)
Woodman, Charles B., 212 South st., Morristown(14)
Woodruff, Ralph G., Main st., Englishtown (13)
Woolbert, Edwin, 15 W. Wash'gton av., Pleas'tv'e(1)
Worcester, George F., 220 Engle st., Englewood (2)
Worcester, John T., 220 Engle st., Englewood (2)
Work, John L., Mountainside Hosp., Montclair (7)
Wortman, Harry C., Jr., 17 Warren st., Nutley (7)
Wortman, Herbert M., 438 Park st.,Up.Montclair(7)
Wren, James C., 79 Everett st., Closter (2)
Wright, Herman W., 818 S. Broadway, Pitman (8)
Wright, Ralph S., 517 Cooper st., Camden (4)
Wright, Robert E., 172 Concord dr., River Edge (7)
Wright, Walter A., 2 Broad st., Bloomfield (7)
Wroblewski, Benj. M., 1166 Thurman st., Camden(4)
Wry, Dean A., 234 Dayton av., Clifton (16)
Wry, Orlin V., 95 High st., E. Rutherford (2)
Wuerthele, Virginia E., 560 Mt. Prosp't av.,New'k(7)
Wuester, William O., 238 Exeter way, Hillside (20)
Wujciak, Henry J., 193 Warwick st., Newark (7)
Wurts, Margaret M., 27 Wellesley av., U. M'tcl'r(7)
Wurzel, Milton, 2 Farley av., Newark (7)
Wyatt, Joseph H., 135 Clinton av., Newark (7)
Wyker, Arthur W., 57 Park pl., Bloomfield (7)
Wylly, Martin D., 320 Park av., Orange (7)
Wyman, Edward H., 100 E. Broad st., Burlington(3)
Wynder, Alfred, 654 Lyons av., Irvington (7)

ASSOCIATE MEMBERS

Walker, John C., Jr., 15 Washington st., Newark(7)
Ware, Charles I., 174 North Main st., Pleas'tv'le(1)
Webb, Wilson D., Jr., 248 State st., Hackensack (2)
Weigele, Carl E., 455 West State st., Trenton (11)
West, Harold, 606 F st., Belmar (13)
White, Ensley M.,Jr.,15 St. Nicholas pl.,Red Bk.(13)
Williams, William E., 9 Ridge rd., Rutherford (2)
Wise, John S., 73 Westcott rd., Princeton (11)
Wortzel, Martin H., 592 South 19th st., Newark (7)

Y

ACTIVE MEMBERS

Yablonsky, Max, 30 Shanley av., Newark (7)
Yachnin, Samuel C., 127 Prospect st., Passaic (16)
Yadkowsky, Emanuel, 637 High st., Newark (7)
Yager, J. Allen, 420 Broadway, Paterson (16)
Yaguda, Asher, 61 Lincoln Park, Newark (7)
Yanowitz, Bernard, 165 Jewett av., Jersey City (9)
Yasskin, Hymen E., 575 Stevens av., Camden (4)
Yates, Glen L., 67 Union st., Montclair (7)
Yates, John S., 414 Ellison st., Paterson (16)
Yazujian, Levon D., 562 E. State st., Trenton (11)
Yeaton, William L., Jr., 204 11th st., Hoboken (9)
Yeaw, Ralph C., 310 Broadway, Paterson (16)
Yelin, Gabriel, 202 Clinton av., Newark (7)
Yellin, Charles H., 915 Jersey av., Elizabeth (20)
Yingling, Paul L., 804 Wesley av., Ocean City (5)
Yolken, Harry, 246 E. 31st st., Paterson (16)
Yontef, Reuben, 851 Avenue C, Bayonne (9)
Yood, Harold S., 401 Grant av., Plainfield (20)
York, Jack S., 63 Baldwin av., Newark (7)
York, James L., 331 River rd., New Milford (2)
York, Wilbur H., Box 110, Princeton (11)
Yorke, Benjamin, 908 Main st., Paterson (16)
Yorke, Edward T., 1717 N. Wood av., Linden (20)
Young, Franklin C., 120 Summit av., Summit (20)
Young, George J., 60 Maple av., Morristown (14)
Young, I. Henry, 220 Columbia av., Irvington (7)
Young, James L., 68 Mountain av., Somerville (18)
Young, Ralph A., 842 N. Wood av., Linden (20)
Yuckman, Robert O., 701 Madison av., Elizabeth (20)
Yudkoff, William, 770 Avenue A, Bayonne (9)

ASSOCIATE MEMBERS

Yaeger, John, 61 Highland av., Yardville (11)

Z

ACTIVE MEMBERS

Zacchino, Arnold A., 1001 Anderson av.,Palisade (2)
Zacher, Andrew A., 685 High st., Newark (7)
Zager, Saul, 40 Spruce st., Newark (7)
Zahn, Jack R., 90 Paterson av., Gibbstown (8)
Zappala, John, 47 W. Main st., Penns Grove (17)
Zbar, Joseph E., 2690 Boulevard, Jersey City (9)
Zdanowicz, Stefan J., 117 Grand av.,Hackettst'n(21)
Zehnder, A. Charles, 188 Roseville av., Newark (7)
Zeitlin, Herman H., 943 N. Wood av., Linden (20)
Zeltmacher, Kurt, 308 W. State st., Trenton (11)
Zick, Clara U., 60 Highland rd., Glen Rock (16)
Ziegler, James E., 28 Mt. Airy rd., Bernardsville(14)
Zigarelli, Joseph F., 275 E. 18th st., Paterson (16)
Zimmer, Louis, 622 Varsity rd., South Orange (7)
Zimmerman, Coler, 6 Colony dr., S., W. Orange (7)
Zimmerman, Robert F.,28Wash'gton av.,Mor'st'n(14)
Zimskind, Joshua N., 210 W. State st., Trenton (11)
Zingali, John A., 103 Glenridge av., Montclair (7)
Zinkin, Solomon B., 328 Second st., Lakewood (15)
Zirpolo, Gene A. V., 1128 Bryant st., Rahway (20)
Zitani, Alfred M., 937 Washington st., Hoboken (9)
Zuck, Arthur C., 22 Broad st., Washington (21)
Zucker, Isadore, 112 Shanley av., Newark (7)
Zuckerberg, Irving, 800 Avenue C, Bayonne (9)
Zuckerman, David E., 568 Broadway, Paterson (16)
Zuckerman, Louis, 568 Broadway, Paterson (16)
Zukerberg, Nathan, 21 Johnson av., Newark (7)
Zuloff, D. Blair, 3 Community pl., Morristown (14)
Zvaifler, Nathan, 46 Wilbur av., Newark (7)
Zweibel, Leonard, 871 S. 11th st., Newark (7)
Zweigel, Isidore, 22 Monticello av., Newark (7)
Zybulewski, Edmund A., 410 Bergen st., Newark (7)

ASSOCIATE MEMBERS

Zutz, Harry, 10 Clinton pl., Newark (7)

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
MAR 6 - 1953	McNevock
~~APR 13 1954~~	[illegible]
NOV 20 1958	VA
	Bronx
JUL 16 1959	US Abroad
~~JUL 12 1967~~	Fed Bates